EXPLORING HIDDEN WORLDS

RURAL AUSTRALIAN YOUNG PEOPLE WHO LOSE A FRIEND TO SUICIDE

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I certify that I am the sole author and that the substance of this thesis has not already been submitted for any degree and is not currently being submitted for any other degree or qualification.

I certify that, to the best of my knowledge, any help received in preparing this thesis, and all sources used, have been acknowledged in this thesis.

Signature 

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ABSTRACT

Suicide is the leading cause of death of young Australians, with rural young people at higher risk. Increasing research has investigated the bereavement experience of people who lose someone close to suicide. However, rural young friends have remained hidden from the research literature and, as such, their grief and experiences are not well understood.

This study provides empirical data from bereavement experiences of young rural people who had lost a close friend to suicide, and continued to live in their rural town where the death occurred. Semi-structured interviews were held with 18 participants, aged between 14 and 23 years, from four different locations in rural Australia. They completed six standardised questionnaires that rated symptoms for depression, anxiety, prolonged grief, coping skills, posttraumatic growth, and stigma, along with questions about their general health and alcohol use. The interview data was analysed to derive narrative themes. The first theme comprised communication about the death and included social media, schools, and rumours. The second theme was the response to the death and how stigma manifests in rural communities.

The third theme was how participants coped after the death, and the ways in which this impacted them. The participants rated significant symptoms of depression, anxiety and prolonged grief, and they consumed alcohol at harmful levels. They were also more inclined to stigmatise and glorify suicide. The study findings highlight that rural young people bereaved by a friend's suicide are at risk of a number of health issues, and these can continue for a number of years after the death. Close friends were not found to be at immediate risk of suicide because of the protective effect of peer-monitoring that results from exposure to the impact of the suicide on family and others. Peripherally related peers were excluded from this protection and potentially at greater risk of suicide contagion.

Recommendations include school postvention guidelines to consider risks for all students, not just those considered close friends. Social media should also be more proactive in response to suicide. Finally, improved mental health literacy must include a discourse about suicide to address the stigma prevalent in rural communities. Recommendations for future research are also canvassed.

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Chapter 1

Introduction

> ***It feels as though every time I go back there it is to say goodbye or for another funeral. On the drive there is this stretch just before you get in, probably about fifteen minutes before you get in, and I get so tense and in the pit of my stomach I feel sick. And I just think, this used to be my home, this used to be a place I loved. Now I struggle to even get back there to say hello. I don't like going back there anymore*** **(Angel, 2009).**

This quote is from a young woman who participated in a prior study examining suicide bereavement (Bartik, Maple, Edwards, & Kiernan, 2013a, 2013b). The participant, then aged twenty-five years, had been telling me about the suicide deaths of her three close friends. All these deaths had occurred in her rural town. All died when she was aged nineteen. Six years later she was participating in this interview on her unit balcony in a major metropolitan city. This powerful statement about location, belonging and home resonated with me for a long time. This participant had moved away from her hometown. She was able to leave. This quote started me thinking—thinking about those who cannot leave; those who lose a friend to suicide, or multiple friends, and have to stay; those who are too young to

leave, those who have to stay. What was their experience and how did they cope with the loss of a friend to suicide?

Around one quarter of young people in Australia reported having a mental health disorder over a 12-month time period and just under one quarter of those young people accessed formal support services (Australian Bureau of Statistics, 2010b). There is significant morbidity and considerable unmet need among young people with a mental health disorder. Whilst not all young people who die by suicide have a mental health disorder, suicidal behaviour is indicative of psychological distress (Australian Institute of Health and Welfare, 2007b). Rural young people are considered to be at higher risk of suicide (Australian Institute of Health and Welfare, 2007a).

In some ways, the higher suicide risk for these young people seems an anomaly with the idyllic picture that is often painted of rural Australia, particularly the imagery portrayed to lure city dwellers as part of a tree change or sea change. The availability of quality health, education, and social support services—essential to support rural populations—are also promoted as key drivers to encourage such population relocation (for example, Evocities, 2013). Rural areas have much to offer young people but they can also present certain challenges with individual, family

and social circumstances being factors associated with increased risk of suicide (Australian Institute of Health and Welfare, 2007b).

The tragic reality is that suicide occurs despite best intentions, service availability and clinician expertise. Suicide occurs across all age groups, but the suicide death of a young person is especially tragic, with huge social and emotional costs to families, friends, and communities (Suicide Prevention Australia, 2010b). The sense of a young life and future potential lost can be unfathomable to most, and the effects are far-reaching, not least for young people themselves, for whom youth suicide is a major concern (Mission Australia, 2013). For family, friends and colleagues bereaved by suicide, the toll is enormous in terms of grief and guilt. This often results in psychological pain that is suffered in silent but profound ways, and can itself lead to higher risk for suicide (Lewiecki & Miller, 2012). Given suicide death occurs at increased rates in rural areas, those residing in such geographies are not only at greater risk of suicidality but also are more likely to experience the death of someone they know.

Guiding research questions

The quote that heads the introduction and the desire to better understand the impact of suicide bereavement on rural young people inspired the current research

study. Better understanding would allow for the development of informed, appropriate and supportive interventions and hence the opportunity to prevent or minimise complications that might arise as a result of this loss. It is the aim of this thesis to redress the gap in knowledge about rural young people's experiences of losing a friend to suicide and in doing so, make recommendations to support their identified needs.

To meet this aim, I used a mixed-method design to examine the experience of rural young people bereaved by the suicide death of a friend. This consisted of a primary qualitative narrative drive supplemented by a quantitative analysis using standardised measures to assess characteristics in the sample of young people. The key questions guiding this research were:

1) *How do rural young people live through and with the suicide death of a friend?*
2) *Are there adverse and/or positive outcomes associated with being exposed to a friend's suicide death?*
3) *Do young people have suggestions for ways in which they need support following this event?*

Quantitative measures were selected for key health issues based on the literature review that identified that young people bereaved by suicide are at increased risk of poor mental health outcomes.

Significance of the research

Self-harm and suicide are major public health problems in adolescents (Hawton, Saunders, & O'Connor, 2012) and the leading cause of death of young people in Australia. The suicide rates for those living in rural and remote locations are three-times that of their counterparts resident in major cities (Australian Government, 2013). Greater social proximity means that young people in rural locations are likely to have increased exposure to the suicide of friends. Such bereavement brings heightened risk for negative health outcomes including mental health disorders, suicidal and other risk behaviours (Bolton et al., 2012; Cerel, Roberts, & Nilsen, 2005).

The primary purpose of this study was to explore the experiences of rural young Australians who lose a friend to suicide. As will be described in Chapter 2, the research is scant, and as such, the experiences of young people who are bereaved by suicide are missing from the literature. Given that investigations of this nature help those seeking to support people bereaved by suicide (Maple, Edwards, Minichiello, & Plummer, 2012), it is important that young people's perspectives are heard to inform the support and interventions offered. However, as young people often feel disempowered by the systems and processes that impact on their lives (Boylan & Dalrymple, 2009), an approach that was empowering was required. In undertaking

this study, I anticipated that rural young people bereaved by suicide would have had limited opportunity to tell their story and that the interview process might provide them with greater understanding of their experience. Young people's specific insights might also identify positive and negative responses from their local rural community that collectively could inform how to better respond to these needs in the future.

Definition of terms

Bereaved by suicide or suicide bereaved

There is considerable international variation in the terminology used to describe someone who is impacted by the suicide death of another. In North and South America and Asia, the term 'suicide survivor' or 'survivor of suicide' is used (Dyregrov, 2011; World Health Organisation, 2008). However, this term can be misconstrued as referring to someone who had survived a suicide attempt. In most other parts of the world and in this thesis, the terms 'suicide bereaved' or 'bereaved by suicide' will be used. These terms are synonymous and refer to a relationship and closeness between the deceased and the bereaved, where there is an impact of the loss on the bereaved (Andriessen & Krysinska, 2012).

Exposure to suicide

Exposure to suicide implies that a person did not personally know the deceased but knows about the death through reports of others, the media, or because they personally witnessed the suicide death of a stranger (Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014).

Postvention

Postvention refers to strategies aimed at helping individuals bereaved by suicide. The term was first developed by Shneidman (1972) and more recently has been defined as "activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviour" (Andriessen, 2009, p. 43).

Young people; young people bereaved by suicide; participants

In this thesis, the term 'young people' is used as a general term for all young people. The term 'young people bereaved by suicide' is used for a specific sub-group of all young people. The term, 'participant/s' is used specifically for young people bereaved by suicide who participated in this study.

Overview of thesis

The aim of the research reported in this thesis was to examine the experiences of rural young people who have lived through and with the suicide death of a friend. The use of a core narrative approach for interviewing and analysis allowed participants to share their stories with me. The supplementary quantitative approach provided for objective measurement of particular characteristics of the participants. The combination of methods highlighted an often-apparent discrepancy between the participant's storied experience and the manifestation of problem and risk behaviours.

Overview of chapters

The current chapter provides the background and overview for this research and includes definitions for the terminology used throughout the thesis.

Chapter 2 presents a comprehensive review of the history and epidemiology of suicide, specifically youth suicide and rural youth suicide in Australia. Risk factors for youth suicide are explored, followed by issues of suicide contagion and suicide clusters with respect to young people. The chapter reviews the literature relevant to suicide bereavement, particularly the bereavement experience and issues for rural young people.

Chapter 3 introduces the theoretical orientation, methodological approach, and research design chosen for the study. A mixed-method design was selected, with a qualitative core as the main theoretical drive for the study, and a quantitative supplementary component, as described by Morse and Niehaus (2009). The research design and analysis process is presented along with considerations of reflexivity, rigour, methodological issues, and limitations. The chapter commences with an introduction of myself as the researcher because of the critical interplay between the stories of the participants and my presentation of their narratives.

Chapter 4 introduces the participants and some of their world by presenting short vignettes that portray the young person who died, when or how, and a sense of the interview environment.

Chapter 5 presents the results of the mixed-method design undertaken for this study. This consists of themes derived by thematic analysis from the narratives of the participants. There were three themes:

- The first theme was communication and how participants were informed about the death of their friend.
- The second theme was the response to the death and the involvement of schools, family and friends, and the local community.

- The third theme was coping after the death and the mechanisms adopted by the participants to manage their grief.

The results from the supplementary quantitative analysis included high rates of alcohol use, depression, anxiety, prolonged grief symptoms, and the participants tended to view suicide in more glorifying and normalising terms.

Chapter 6 provides a discussion of the findings from the study. Three key items are discussed with consideration of the existing literature. The first is communication and the role of social media and communication from schools, and how this impacts grief and bereavement of young people exposed to suicide. The second item is the rural community context and its influence on stigma, gatekeeping and responses to young people. The third item is the continuum of risk for young people exposed to suicide and the resulting individual adversity and growth.

Chapter 7, the final chapter, draws together the narrative themes and quantitative results to investigate how young friends live through and with the suicide death of a close friend in rural Australia. A number of practice implications are discussed to better support bereaved young people, giving clarity to the recommendations made in this chapter. These include social media, support following a suicide death, and school responsiveness in the aftermath of a student's suicide death. Finally,

strengths and limitations of the study are discussed, together with recommendations for future youth suicide bereavement research.

Chapter 2

LITERATURE REVIEW

SUICIDE

This chapter commences with a description of the historical background pertaining to suicide, as well as key theoretical understandings of suicide. Suicide epidemiology is then reviewed from the Australian perspective, followed by a focus on suicide and young people. Matters of young people's development and transition, youth mental health, and the costs of youth mental illness and youth suicide are then presented, followed by how young people socially construct issues such as suicide, help negation, and stigma. Risk factors relating to youth suicide are then discussed, together with suicide contagion and suicide clusters. Specific data related to youth suicide and rural youth suicide in Australia is then presented. The literature relevant to suicide bereavement is discussed, including issues that people bereaved by suicide may experience. In the final section, research specifically addressing the suicide bereavement experience of adolescents, particularly Australian rural adolescents, is presented.

Suicide historical background

Suicide has been deemed to have existed since the Antiquities (Minois, 1999) with speculation that the first recorded suicide note, from ancient Egypt, dates from around 2000BC (Thomas, 1980). The ancient Greeks viewed suicide within moral codes of shame and honour, regulated by society's view of the individual (Garrison, 1991). The writings of both Plato and Aristotle made distinctions between acceptable and unacceptable suicide. Honourable suicide, resulting from judicial order or shame from participating in unjust actions, was recognised to be acceptable. Cowardly suicide, where the person desired to escape from hardships, was condemned (Garrison, 1991). In the 4th-century, St Augustine's proclamations prohibiting suicide demonstrated Christianity's hardening attitudes, which then became the official doctrine and the position of the Church (Minois, 1999). On this basis, suicide was considered a mortal sin against God that resulted in the denial of proper burial rites and eternal damnation (Minois, 1999). This heralded the origins of the current stigma associated with suicide and those who died by suicide.

Fifteenth-century humanism and the period of the early Renaissance saw a contrary position on suicide to that of the traditional Christian perspective. Suicidal tendencies were linked to melancholy and thus considered from a basis of illness rather than satanic sin (Minois, 1999). However, tensions still existed between canon

law, civil law and, increasingly, Roman law with regard to the burial and distribution of property of those who died by suicide. Religious theology maintained the view that suicide was not only an act against God, but also against society and the person. Despite this, medical theories began to increasingly link melancholia and mania with suicidal tendencies where incarceration within asylums was believed to prevent suicide (Minois, 1999).

The eighteenth-century and the period of the Enlightenment saw scientific thought and philosophical consideration brought to the subject of suicide. The purely religious and theological arguments espoused since at least St Augustine were abandoned (Minois, 1999). It was also during this time that the term suicide was first used in reference to the English malady (Minois, 1999). Suicide had, at this time, "emerged from the ghettos of taboos and unnatural acts" (Minois, 1999, p. 314) but following the French Revolution, it again became considered to be forbidden and against nature.

In the nineteenth-century suicide was considered a mental, moral, or physical weakness of the individual. Suicide became "repressed and classified with the other great social prohibitions" (Minois, 1999, p. 320). In Western countries, this view has largely continued to pervade modern thinking about suicide. Whilst suicide was no

longer a crime in most countries, the reproachful silence and resultant taboo that surrounded suicide contributes to the current stigma (Minois, 1999).

Suicide theory

Whilst suicide has been recorded as part of human history since at least 2000BC, our understanding of the phenomenon remains incomplete. This limits the capacity to respond to, and reduce, the number of people vulnerable to dying by suicide. Van Orden and colleagues (2010) argue that attempts to advance an empirical understanding of suicide are hampered due to the absence of a comprehensive theory that can explain known facts and predict the risk of future suicidal behaviour. Much is known about suicide and suicide behaviour with regard to risk factors yet, while risk factors can increase the probability of suicide as an outcome, they do not provide a causal explanation. A number of theoretical explanations of suicide have been developed over time, with four key exponents—Durkheim, Freud, Shneidman and Joiner—discussed here in chronological order.

Emile Durkheim: Sociological aspects of suicide (1897-1917)

The French philosopher Emile Durkheim was one of the first scientists to develop a comprehensive theory of suicidal behaviour supported by statistical data (Selkin, 1983). Proposing a sociological perspective to suicide, *Le Suicide* (Durkheim,

1897/1951) argued that suicide was not the result of an individual's action but of social disorganisation where there was a lack of social integration or solidarity. His basic conclusion was that vulnerability to suicide varied with social integration, social structure, and social change (Selkin, 1983).

Durkheim identified four types of suicide that were based on the different relationships an individual might have with society:

1) Egoistic suicide, where a person becomes socially isolated or feels they no longer have a place in society. Here, suicide is a consequence of the deterioration of social and familial bonds (Kushner & Sterk, 2005), where the person lacks altruistic feelings and whose attachment to society is tenuous and weak. Attachment can be weakened through the loss of family and friends, retirement, separation and divorce. Those deemed as socially deviant are cut-off from society's mainstream.
2) Altruistic suicide, which occurs when the individual and the group are too close and intimate. The individual is so well integrated into society that they sacrifice themselves out of a sense of duty to others. Examples have included elite military groups, cults, and deeply committed religious groups who often exhibit high suicide rates out of principle for expected group behaviour (Selkin, 1983). When the person is so closely tied to rituals and beliefs of the

group, they can lose any sense of individuality (Stack, 2004) and take their own life because they love the group more than they love themselves (Durkheim, 1951).

3) Anomic suicide is due to the breakdown in social order and equilibrium between an individual and society (Robertson, 2006). This can occur with major shifts in the distribution of wealth, such as following bankruptcy or after receiving a windfall such as a lottery win. Breakdown can also emerge from geographical isolation, disenfranchisement, and cultural alienation (Robertson, 2006) where society does not regulate individuals sufficiently. Anomic suicide occurs in response to the disruption of norms and values by rapid social changes that lead to uncertainty, such as during times of economic depression or boom/bust economic cycles.

4) Fatalistic suicide is due to excess or over-regulation in society. Durkheim considered that when society restricted an individual too much, such as the case of a servant or slave, they experienced pervasive oppression that could then result in fatalistic suicide. However, Durkheim determined that almost no contemporary examples of fatalistic suicide could be found and thus dismissed its modern day context (Kushner & Sterk, 2005). This view however, runs counter to statistical data and certain cultural considerations. For example, higher suicide rates are recorded among married women in

> some non-Western countries where roles are regulated and restricted (Aliverdinia & Pridemore, 2009). Durkheim also considered that women were mostly socially integrated within the model of a traditional family and thus immune to suicide. Yet women who are most subsumed in traditional institutions are most at risk, with the higher rates of suicide attempts by women indicative of "their profound unhappiness" (Kushner & Sterk, 2005, p. 1141).

Despite the seminal nature of Durkheim's thesis on suicide, parts of his theory have not stood up to the test of rigorous research (for example Bernburg, Thorlindsson, & Sigfusdottir, 2009). Durkheim's inductive method is largely untestable and based on the acceptance of suicide data from a number of sources with highly variable levels of methodological soundness (Robertson, 2006), partially explained by the era of his theorising and writing. This timeframe also contributes to the 'Western-centric' view of suicide presented by Durkheim, where data from cultures that did not fit the theory may have been excluded (Stack, 2004), or data was not available to adequately assess it against the developing theory. Perhaps the biggest contention of Durkheim's theory is his dismissal of mental illness as a major factor in suicide, with decreased social integration and functioning seen as a consequence of psychiatric impairment rather than a cause in and of itself (Robertson, 2006).

Sigmund Freud: Motivation and instincts (1896-1939)

The view of suicide as a product of disordered functioning, and hence appropriate for intervention and clinical objectivity, is largely a phenomenon of the 20th century. Freud is credited for beginning efforts to develop the first psychological, rather than sociological, understanding of suicide (Ellis, 2001). While Freud only wrote sporadically about suicide and never proposed a comprehensive theory, his case histories are pervaded by reports of suicide ideation with the communicative aspect of suicide manifest as a cry for help (Piven, 2004).

Freud's theory of Unconscious Motivation of Behaviour applies to suicidality. His case studies observed a variety of motivations for self-destruction that included self-punishment, revenge, and seeking attention (Ellis, 2001). Freud's view of suicide was derived from his observation that "depression is an attempt to regain through introjection a lost object that is both loved and hated" (Hendin, 1991, p. 1153). The hate originally directed toward the object is displaced to an internal representation of the object, with the hated person destroyed by destroying the self. In Freud's view, suicide is ultimately an act of revenge (Hendin, 1991), and his early writings explained suicide as aggression turned against the self (Minois, 1999). Freud later developed his views to include the death instinct, which was generally

kept in check by the ego defences but could be unleashed in the punitive part of the superego, and thus self-destruction (Ellis, 2001).

Criticism of Freud's psychoanalytic theory is generally based on the issue of falsification that prevents rigorous testing of his theory. His views, and the development of the death instinct, seem to have been invoked from a desire for theoretical consistency rather than based on empirical evidence. However, some of the key processes identified by Freud, including the libido as the principal energy of the nervous system, with motivation as part of the id and cerebral energy as part of the ego, have been proposed through neuroimaging to match a number of physiological correlates in the brain (Carhart-Harris, Mayberg, Malizia, & Nutt, 2008). This suggests a new level of scientific verification for the subjective phenomenon relevant to psychoanalytic theory.

Edwin Shneidman: Psychache (1955–2009)

Shneidman was a clinician (psychologist) who came to suicidology through trying to understand the lived experience of suicide (via deceased people's suicide notes). He viewed suicide as the desire for escape from psychological pain (Van Orden et al., 2010). Shneidman's work and writings have had a pervasive impact on modern day explanations of suicide, with five key notions (Shneidman, 1993):

1) Suicide is best understood as a movement away from some intolerable situation, pain or anguish.
2) Suicide is best understood not by using taxonomic labels such as depression, but rather in terms of personality functioning, specifically perturbation (how distressed) and lethality (how deathly suicidal).
3) Suicide should be considered a transient constriction or narrowing of options that might usually be available to the particular individual.
4) Suicide is a reaction to frustrated or unfulfilled psychological needs.
5) Suicide is the idea of cessation and, specifically, the complete stopping of one's consciousness of enduring pain, which is considered by the suffering individual as the perfect solution to their life's painful and pressing problems.

Shneidman's emphasis on perturbation and lethality offered new explanatory power to the understanding of why suicide occurs (Shneidman, 1971). Given Shneidman's clinical focus, he wrote that the degree of self-destruction (lethality of method chosen) and degree of distress or unbearable psychological pain (perturbation) were essential implications for psychotherapy and that the therapist should make daily assessments of both (Shneidman, 1993). To treat high lethality, Shneidman proposed that the therapist should do whatever it takes to reduce the

patients sense of perturbation including addressing their dependency needs and their sense of pressure and futility, as well as cater to their "infantile idiosyncrasies" (Shneidman, 1993, p. 26).

Shneidman's definition of suicide involved an individual's tortured and tunnelled logic in a state of inner-felt, intolerable emotion. This constricted thinking and unbearable anguish was infused with the individual's conscious and unconscious psychodynamics (for example, hate, dependency, hope) played out within a social and cultural context, which imposed degrees of restraint on, or facilitations of, the act of suicide (Shneidman, 1973a). Shneidman identified suicide as a conscious self-serving act best understood as a multidimensional ill being in someone vulnerable who perceives self-extermination as the best solution (Minayo, Cavalcante, & de Souza, 2006).

A key contribution of Shneidman's was in the area of postvention following suicide. He coined this term as "activities which occur after a suicidal event… [and that] postvention aims primarily at mollifying the psychological sequelae of a suicidal death in the survivor victim" (Shneidman 1969 quoted in Andriessen, 2009, p. 43). Whilst Shneidman's theory was based around psychache, and this was homage to subjective internal motivation and hence the problems of falsification, his definition

enabled greater operational focus and research attention, partially due to his grounded location within the lives (notes) of those who had died, and those who had survived attempts on their life.

Thomas Joiner: Interpersonal Theory of Suicide (1999–ongoing)

Thomas Joiner (2005) proposed that, whilst "responsibilities for life choices resides with patients" (p. 19), three factors increase the level or risk of suicide for an individual: first, burdensomeness or the feeling of being a burden on loved ones; second, a sense of isolation; and third, a learned ability to harm oneself, built upon exposure to pain. Joiner described the need to belong as a central component associated with suicide, consistent with the link between social connectedness and suicidal behaviour. These views are central to the *Interpersonal Theory of Suicide* (ITS) (Joiner, 2005) that has been developed to account for the diverse array of factors associated with suicide.

At its foundation, the ITS is grounded in the idea "that people die by suicide because they can and because they want to" (Van Orden et al., 2010, p. 8). This theory posits that suicide desire is at its most dangerous when there is the simultaneous presence of thwarted belongingness and perceived burdensomeness as well as one construct related to the acquired capability for suicide.

Thwarted belongingness refers to social isolation, specifically, the lack of, or loss of, social connection such that, when this need is unmet, a desire for death develops. The need to belong is considered a dimensional (rather than categorical) and dynamic cognitive-affective state (rather than a stable trait). The construct relates back to Durkheim's theory where a lack of, or change in, social integration results in suicide. However, as Van Orden and colleagues point out (2010), Durkheim's theory can provide explanations for patterns or shifts in suicide rates but, because it does not consider individual factors, it cannot explain why, if all individuals are exposed to social forces, only particular individuals die by suicide.

Perceived burdensomeness is the elevated likelihood of developing perceptions of being a burden on others and comprises two dimensions of interpersonal functioning: "beliefs that the self is so flawed as to be a liability on others, and, affectively-laden cognitions of self-hatred" (Van Orden et al., 2010, p. 12). The liability dimension consists of six observable risk factors: distress from homelessness; distress from incarceration; distress from unemployment; distress from physical illness; expendability and feeling unwanted; and a belief that one is a burden on family and others. The self-hate dimension consists of three corresponding observable indicators that have demonstrated empirical association with suicide: low self-esteem; self-blame and shame; and agitation. Perceived

burdensomeness is also presumed to be both a dynamic cognitive state, and dimensional, meaning that its levels vary over time and along a continuum of severity (Van Orden, 2010).

The final part of the ITS is the acquired capability for suicide which consists of increased tolerance for pain and reduced fear of death. This is developed through "habituation and activation of opponent process, in response to repeated exposure to physically painful and/or fear inducing experiences" (Van Orden, 2010, p. 15).

Where Durkheim and Freud were proposing theories for understanding and Shneidman added a clinical domain, Joiner's (2009) ITS invites both clinical and "scientific inquiry and potential falsification" (Van Orden et al., 2010, p. 2) of its central hypotheses to further extend the need of suicidology. This inquiry has commenced with accumulating research finding support for the constructs within the military (Selby et al., 2010), and community and clinical population samples (Van Orden, Cukrowicz, Witte, & Joiner, 2012). However, more equivocal results have been found in other studies. For example, Lester and Gunn's (2012) study of suicide notes for evidence of perceived burdensomeness and thwarted belongingness found that these constructs were rarely both present in the notes examined. Regardless of the state of inquiry, it has been acknowledged that Joiner

and the ITS has stimulated new areas of suicide research, extending knowledge in this area (Lester, 2013).

Suicide epidemiology

It is important to consider suicide theory with respect to the considerable data published about suicide. Internationally, suicide accounts for nearly one million deaths per annum (World Health Organisation, 2012). This represents a global mortality ratio of 16 deaths per 100,000, with an increase of 60% over the last 45 years. Suicide rates indicate that people younger than 21 years are the highest risk group in one-third of countries (World Health Organisation, 2012). Based on epidemiological research from high-income countries, the World Health Organisation (2011) reports that global suicide rates are more than three-times higher in men than in women. However, China and India account for about 50% of all suicide deaths (Varnik, 2012), and because of their suicide gender ratios, the global male-to-female ratio for suicide rates is reported as 1·67 (male) to 1 (female) (Phillips & Cheng, 2012).

Suicide in Australia

In 2012, Australia had 2,535 registered suicide deaths, comprising 1901 males and 634 females. However, the Australian Bureau of Statistics (ABS) (2014) cautioned

that the revisions process and new coding guidelines established following the senate inquiry may result in an increase in these official statistics as each year is reviewed. The current number of registered suicide deaths represents an age-standardised ratio of 11.2 deaths per 100,000 population (Australian Bureau of Statistics, 2014). In contrast to international trends, the suicide rate in Australia has remained relatively stable over the past 10 years (Australian Bureau of Statistics, 2012), but rates vary across the lifespan with regard to age, gender, and cultural background. In Australia, males account for 75% of all suicide deaths, with the highest rate of suicide death in males older than 85 years (37.6 deaths per 100,000 males; Australian Bureau of Statistics, 2014). However, rates are high in young people at a time of otherwise good health and low mortality. Some groups, including those with mental illness or from Aboriginal Torres Strait Islander backgrounds, also experience higher rates of suicide death (Australian Bureau of Statistics, 2013; SANE Australia, 2013).

The past twenty years has seen a change in the type of suicide method used in Australia, with significant reductions in suicide death for both males and females involving firearms, gassing, and poisoning (Australian Bureau of Statistics, 2014). These changes are primarily attributed to legislative advances such as the control and availability of firearms and motor vehicle exhaust catalytic converters, as well

as the declining use of first-generation tricyclic anti-depressant medications (Large & Nielssen, 2010).

Nearly one-third (31% or 6,886,600 people) of the Australian population reside outside major cities (Australian Bureau of Statistics, 2011). Slower rural growth rates have resulted in both a decline and redistribution of rural populations, which in turn resulted in economic and social impacts (Australian Bureau of Statistics, 2011). Rural communities appear to be at heightened risk for a number of negative socio-economic factors (Australian Bureau of Statistics, 2009). These include lower income and unemployment, greater social isolation, lack of social services, lower levels of mental health literacy, and lower levels of social capital that highlight social disconnection and marginalisation. These factors have been linked to suicide and mental health issues in rural areas (McNamara, 2012), along with rural occupational issues, stressors related to climate change, greater access to more lethal means, alcohol and other drugs issues, and cultural influences (Kölves, Milner, McKay, & De Leo, 2012).

The higher rates of rural suicide in Australia are especially reflected in male deaths (NSW Department of Health, 2010), which also tend to increase with geographical remoteness (McNamara, 2012). Male suicide rates in Australia have consistently

been higher in small country towns compared to metropolitan areas, particularly towns with populations fewer than 4000 people (Bourke, 2003). However, there is considerable variation across rural areas "with some communities having higher rates and rates changing from year to year" (Bourke, 2003, p. 2356). This reinforces that there is no one homogenous rural community across Australia, and there are different risk and protective factors across communities. This means that prevention and intervention strategies need to be individualised for particular rural locations (Kölves et al., 2012).

Suicide and young people

Whilst there is considerable published literature about suicide in Australia and globally, less is known about suicide and young people. The following section considers Australian youth suicide. First, youth development and transition is presented, followed by youth mental health, and the costs associated with youth mental health and suicide in Australia. Following this, the social construction of youth suicide and youth suicide risk factors are presented. Youth suicide and rural youth suicide are then discussed.

Young people: Development and transition

Adolescence and young adulthood are critical life developmental stages, particularly influential for mental health and wellbeing, together with the establishment of adult behavioural patterns (Clark et al., 2013; Rickwood, Dean, Wilson, & Ciarrochi, 2005). These changes include physical development, cognitive and emotional changes, identity and development of values, relationships, and the development of future aspirations. Transitions from childhood to adolescence and to young adulthood are characterised by self-exploration, with acceptance (particularly by peers) crucial to a robust sense of self-worth. Therefore, factors that might increase the likelihood of young people feeling marginalised or socially isolated are particularly important. Issues associated with sexual orientation, body image, bullying (including via social media), and learning difficulties may be particularly relevant (Commonwealth of Australia, 2011a)

Some young people can be vulnerable due to their more limited life experience as well as the absence of parental or other adult supervision. Other young people may engage in risky behaviour, with alcohol and drug misuse common in the age group (Stanley et al., 2009). Development during this stage of transition can also be disrupted by factors such as family separation and school exclusion, which can result in homelessness and the associated increase in poor health (Stablein &

Appleton, 2013). Pervasive shifts in these social contexts and connections, coupled with reduced structure and social support, can predispose young people to difficulties. Failure to negotiate these shifts can have serious implications for mental health (Hooven et al., 2012). Childhood adversities such as physical abuse, sexual abuse and trauma can have a major impact on later adolescent development and are particular risk factors for suicide (Bruffaerts et al., 2010).

Young people also experience marginalisation from the community because the term 'youth' is often associated with disruption, rebellion, irresponsibility, and other negative or dismissive terms (Bourke, 2003). Suicidal behaviour in young people can be seen as impulsive and attention seeking, whilst at the same time "constructed as powerless, immature and in need of help" (Bourke, 2003, p. 2357). Young people can become further marginalised with respect to mental health and suicide due to their own core beliefs that support maladaptive coping strategies and isolative behaviour (Gould, Velting, et al., 2004). The way young people cope with mental health problems, but also how they cope during adolescence in general, may be precursors to how they continue to cope throughout adulthood (Gould, Kleinman, Lucas, Thomas, & Chung, 2004).

Adolescent cognitive development at this time consists of more concrete thinking: complex phenomena are generally more understood in black and white terms. This can result in flawed thinking—such as "I will always feel this bad"—which can lead to escapist thoughts and potentially suicide as a consequence (McNamara, 2012). There is also evidence that deficits in problem solving are associated with suicidal behaviour, although variables such as depression and hopelessness are also implicated (Speckens & Hawton, 2005).

Youth mental health

Mental health is defined as a state of wellbeing in which every individual can realise his or her own potential, cope with the normal stresses of life, work productively and fruitfully, and is able to make a contribution to her or his community (World Health Organisation, 2013). In contrast, and within a clinical context, mental illness or a mental disorder, is defined as a clinically recognisable set of symptoms that relate to mood, thought, cognition, or a behaviour that is associated with distress and interference with functioning—impairments that limit activity and restrict participation (Department of Health, 2005).

It is generally accepted that both mental health and mental illness are determined by multiple and interacting social, psychological, and biological factors. Mental

health can be negatively impacted by individual or societal factors including economic disadvantage, poor housing, lack of social support, and the level of access to, and use of, health services. A range of factors can contribute to mental disorders in children and young people (Patel, Flisher, & McGorry, 2007). This can include developmental factors such as prenatal brain damage or neural causes, genetic factors, low intelligence, physical and intellectual disability, poor social skills, and low self-esteem (Department of Health and Aged Care, 2000). Other contributing factors can include: being bullied, failure to achieve academically, physical or psychological trauma such as sustaining injuries, experiencing abuse or neglect, witnessing family violence, and the loss of family. In addition, stress associated with poverty and social disadvantage such as homelessness, recent immigration or refugee status, and racism and discrimination, can impact on young people's mental health (Correa-Velez, Gifford, & Barnett, 2010).

The emergence of mental illness in adolescence and early adulthood coincides with young people completing their education and pursuing employment options. Youth mental illness impacts on schooling through a number of factors such as increased absenteeism, dropout rates, and difficulty learning, which can then compound both tertiary education and later employment (Degney et al., 2012). While there is significant comorbidity of mental illness in young people with other

disorders such as substance abuse and chronic illness, there are also complications with physical health illnesses, such as HIV/AIDS (Patel et al., 2007). Young people who are same-sex attracted, transgender, or inter-sex, are also more vulnerable to symptoms of depression and anxiety and are up to six-times more likely than heterosexual young people to have a range of mental health problems and disorders (Department of Health, 2004).

Among young Australians aged 15 to 24 years, mental disorders account for 49% of the burden of disease measured by both death and disability (Australian Institute of Health and Welfare, 2007b). Young people appear to be suffering mental health problems at an earlier age, experiencing them at higher rates, and retaining this increased risk into older age (Eckersley, 2008). However, the actual likelihood of increasing rates of mental disorders in young people is subject to conjecture (Costello, Foley, & Angold, 2006): recall bias and the likelihood that older people may forget episodes of earlier illness potentially influence findings (Patel et al., 2007). Compounding this could also be a lowered recognition of depression (Jorm, Christensen, & Griffiths, 2005) and the more limited acceptance, particularly in younger males, of mental illness such as depression. This is evidenced by low levels of professional help-seeking among young people with a mental disorder (Australian Institute of Health and Welfare, 2007b).

Mental illness in young people has a far-reaching impact that extends beyond the individual. There are major implications for government service provision and economic productivity (Degney et al., 2012), thus impacting on society more broadly. Put simply, mental illness in young people brings with it substantial human and economic cost. Young males, perhaps because of their greater risk for suicide, are the subjects of a number of publications that examine the economic costs of mental illness (Pitman, Krysinska, Osborn, & King, 2012). However, there are virtually no cost analysis studies or economic cost reports available for mental illness in young women. This is despite one in three young women aged 16 to 24 years experiencing a mental illness each year (Australian Bureau of Statistics, 2007) and that women are twice as likely as men to access mental health services (National Rural Health Alliance, 2009b). Recent calls for a gendered approach to mental health and well-being (Women's Health East, 2013) support the unique mental health needs of women. This may result in future increased research and publication of health and economic costs for mental illness in young women.

Mental health of young people in rural Australia

Those aged younger than 25 years make up about 34% of the rural population, which equates to a population of about 2.34 million young people (Australian Institute of Health and Welfare, 2008). Research shows that the psychological,

physical, and social concerns of rural young people are not too dissimilar to that of their metropolitan peers (Black, Roberts, & Li-Leng, 2012; Boystown, 2010). However, youth suicide has been identified as a central issue of concern to rural young people, suggesting structural disadvantages in rural areas that impact adversely on health outcomes, particularly risk-taking behaviour (Quine et al., 2003).

Research has shown that self-assessed health can be a strong predictor of mortality and morbidity for some population groups (Australian Bureau of Statistics, 2011). The National Health Survey (Australian Bureau of Statistics, 2007) found that people aged 15 years and over, who lived outside major cities, were less likely to think their health was excellent or very good compared to their peers who lived in major cities. They were also more likely to think that their health was fair or poor. In addition, people who lived outside major cities were 16% more likely to report that they had a mental or behavioural problem. Risky drinking levels were also higher for people, particularly males, who lived outside of major cities (Australian Bureau of Statistics, 2011).

While both rural and urban young men and women suffer from anxiety and depression, young men have higher rates of suicide, antisocial behaviour, and drug

and alcohol problems compared to young women (Degney et al., 2012). Rates of depression in rural young people have been found to be considerably high, especially in young females, with findings suggesting it is not rurality affecting prevalence but rather, particular community characteristics and specific stressors, such as life events and interpersonal relations (Black et al., 2012).

Costs of youth mental illness and youth suicide in Australia

The total direct health costs for Australian young men aged 12 to 25 years with a mental illness is calculated at $555.8 million per annum: 67.8% of this cost is borne by government, with the remaining 32.2% from payments by individuals (Degney et al., 2012). These direct costs include: high level residential care, hospital expenditure, out of hospital expenditure, and pharmaceutical costs. The mortality cost for young males with mental illness is calculated at $1056.7 million. This represents lifetime stream of illness costs attributable to premature mortality. Adding the categories of health, employment, unemployment, imprisonment, disability and mortality increases the total estimated costs of mental illness in males (aged 12 to 25 years) to $3.27 billion per year (Degney et al., 2012).

Suicide is the leading cause of death among young people, and adds considerably to economic cost. This broader economic cost needs to be considered along with the

tragic human cost that impacts family, friends, and communities. Substantial service costs can be incurred leading up to, and immediately following, suicide. These include direct costs such as, police, ambulance, coronial and counselling support. There are also indirect costs from lifetime lost productivity due to premature mortality. The economic cost of suicide in Australia in 2012 was estimated at $1.7 billion with 90% of that cost attributed to male suicide (KPMG Health Economics, 2013). The total cost of all suicidal behaviour in Australia per annum has been calculated at $17.5 billion in 2007-08 dollars (Lifeline Australia, 2010). In 1999 (the most recent numbers available), the estimated costs for 15 to 24-year-olds dying by suicide in Australia was $114 million, although this figure did not include lost productivity (National Health and Medical Research Council, 1999). Lacking in the Australian and international research is the impact of suicide on the wellbeing of those close or connected to the person who died.

Social construction of suicide, help negation and stigma

How young people make sense of suicide as a concept, and as something that might–or does–happen to those around them, has major implications for their own behaviours and help-seeking responses. Individual understandings of suicide are "profoundly embedded within the culture and structure of communities" (Fullagar, Gilchrist, & Sullivan, 2007, p. 1447). Youth suicide appears to be understood

differently by young people compared to adults. For example, Bourke (2003) investigated young rural Australians' understanding of suicide. Young people spoke about suicide in terms of a response, whereas adults discussed suicide as an isolated and disturbing issue. Bourke (2003) stated that this finding supported the view that "young people see suicide as a solution rather than a problem" (p. 2363). Suicide as a solution is very much based in Shneidman's psychache and escape from psychological pain. It is also reflected in views of suicide among young people in Aboriginal communities (Tighe, McKay, & Maple, 2013). Young people construct their views about suicide "through a language of speculation about why and how it happened" (Fullagar et al., 2007, p. 10), meaning that they discuss and hear about suicide from a variety of sources including peers, gossip and the media. The current absence of public and professional discourse about youth suicide can reinforce stigma and taboo, as well as prevent young people from disclosing suicidal feelings (Fullagar et al., 2007).

Young people's reluctance to seek help is a common concern (Gilchrist & Sullivan, 2006a). Wilson and Deane (2012) have defined this as help negation, which refers to the help avoidance that has been found in adolescents who experience clinical and subclinical levels of suicidal ideation and symptoms of psychological distress including depression (Commonwealth of Australia, 2011a). Importantly,

adolescents with higher levels of psychological symptoms report they are more likely to seek help from no one (Wilson & Deane, 2012). Common barriers include confidentiality concerns, a preference to self-manage the problem, a perception that no one else can help, as well as not knowing where to access help (Francis, Boyd, Aisbett, Newnham, & Newnham, 2006).

Issues such as stigma, fear, and the impact of self-esteem have generally been considered in the literature as to why certain groups are less inclined to seek support from appropriate services (Gilchrist & Sullivan, 2006a), however, social networks can also influence help-seeking behaviour. This is particularly relevant for young people whose informal support networks may not function well. This can result in young people feeling isolated and suspicious of peers (as well as parents) because of confidentiality issues (Gilchrist & Sullivan, 2006a). Young people may also perceive that their friends and family are struggling with their own issues and either "do not wish to add to this burden or feel that the prospects of support are limited" (Gilchrist & Sullivan, 2006a, p. 83).

Stigma is defined as "the social disapproval of individuals or groups due to a discredited characteristic that distinguishes them from others" (Suicide Prevention Australia, 2010a, p. 4). Goffman (1963) described stigma as an attitude that was

deeply discrediting and one that tainted and labelled an individual. The social stigma that results from this labelling process is derived from both actual and imaginary 'discriminatory' experiences that can change a person's self-identity.

The strong association between suicide and depression means that suicide carries the stigma of mental illness (Bourke, 2003). People in rural areas, especially males, may feel ashamed or embarrassed to ask for help due to an entrenched and pervasive culture of self-reliance (McColl, 2007). Both rural pride, based on self-reliance and independence, and the shame of having a mental illness can be a major deterrent to help-seeking. Targeted interventions for people with mental health issues, and who may also be at risk of self-harm and suicide, rely on the self-identification of those individuals at risk. However, if those at risk are unlikely to self-identify with mental health issues, they are likely to miss out on this type of assistance.

McColl (2007) argues that, although rural communities usually have high levels of social support, resilience, trust and civic responsibility, these are reduced or often absent when it comes to mental health issues. The collective fear and stigma of mental illness and the conspiracy of silence about its existence, immobilises the classic dynamic of neighbours helping neighbours. Knox and colleagues (2004)

argue that the stigma associated with help-seeking behaviour and mental health issues represent a significant community risk factor for suicide prevention.

Youth suicide risk factors

Whilst there is no single cause of suicide, it is generally accepted that psychosocial stressors can impinge on a vulnerable person to promote suicidal thoughts and then behaviour with varying degrees of lethality and intent (Judd, Cooper, Fraser, & Davis, 2006). Youth suicide is a complex phenomenon that usually results from a combination of risk factors (Beautrais, 2000; Stanley, Mallon, Bell, & Manthorpe, 2009) that, when grouped together, cause the greatest risk for young people (Suicide Prevention Australia, 2010b). For young people, these are generally conceived of as individual, social and contextual risk factors. These three areas are explored below.

Individual risk factors

The high rate of mental disorders in young people has a major impact on youth suicide. Around the world, 90% of young people who died by suicide, or made a suicide attempt, were found to have had at least one mental health problem, usually depression (Hooven, Snedker, & Thompson, 2012; National Health and Medical Research Council, 1999). Alcohol and illicit drug use is high in young people (Muir

et al., 2009) and abuse may increase their risk of suicide (Pompili et al., 2010). Sixty-eight per cent of male suicides and 29% of female suicides provided evidence of an alcohol disorder via psychological autopsy (Kölves, Varnik, Tooding, & Wasserman, 2006). There is an estimated 200 suicide attempts for each suicide death in young people, and a quarter of those treated in an emergency department for their attempt will make a further attempt. Up to 10% of those young people will eventually die by suicide (Larkin & Beautrais, 2010). Further, the risk of suicide from self-harm is at least 10-times higher in adolescents (Hawton et al., 2012).

Social risk factors

Childhood adversity and traumatic life events, together with conflict between parents (Kölves, 2010), childhood relationship problems (Hawton et al., 2012), and school relation problems including bullying and resultant social isolation, constitute major risks for youth suicide (Seguin, Renaud, Lesage, Robert, & Turecki, 2011). Young people who may be suicidal are also resistant to accessing mental health services. For example, Wilson and Deane (2012) report that 75% of adolescents who would benefit from mental health care do not seek or engage with this care. Instead, they prefer not to seek help from anyone for personal or suicide problems (Wilson, Deane, & Ciarrochi, 2005b). For many young people, this reluctance to pursue support is partly due to perceptions of long waiting lists and limited availability

(Black et al., 2012). Indigenous young people have a higher risk of suicide than non-Indigenous young people due to higher levels of psychological distress (Australian Institute of Health and Welfare, 2012; Hunter & Milroy, 2006), social exclusion, discrimination, and other social factors (Robinson et al., 2011; Suicide Prevention Australia, 2010b). Finally, young people can experience homophobia and bullying because of their sexual identity and this experience, with its impact on isolation, emotional wellbeing and stigma, can increase suicide risk (Gilchrist & Sullivan, 2006b; Suicide Prevention Australia, 2010b).

Contextual risk factors

Youth suicide rates are higher in socio-economically disadvantaged areas. Low income increases vulnerability to social disadvantage and can also result in low educational achievement and unemployment, which in turn can lead to poor mental health and suicide risk (Eldridge, 2008). Being homeless also increases the risk of suicide for young people (Department of Health, 2005), as some of the causes of youth homelessness, such as family violence and neglect, are themselves associated with youth suicide risk (Kidd, 2006). Young people in juvenile detention or on remand also have a higher risk of both self-harm and suicide (Sawyer et al., 2010). Having contact with the police or juvenile justice is also a risk factor. Thirty-eight per cent of young people who died by suicide (in Queensland) had prior

contact with police or the youth justice system (Commission for Children and Young People and Child Guardian, 2009) before their death. Suicide risk in these situations is most likely a consequence of distress from possible incarceration, or perhaps related to the increased likelihood of deviant behaviour among those already vulnerable to suicide (Suicide Prevention Australia, 2010b). Other key contextual suicide risk factors for young people include living in rural and remote Australia and suicide contagion.

Suicide contagion, clusters, imitation and transmission

Suicide contagion is a key contextual risk factor that has been the focus of increasing research interest, particularly among young people. The phenomenon of contagion largely developed from Goethe's novel *The Sorrows of the Young Werther* (first published in 1774) in which the main protagonist dies by suicide. It was claimed subsequently that people in many countries imitated Werther's manner of death, although "widespread imitation of Werther's suicide was never conclusively demonstrated" (Phillips, 1974, p. 340). In his book *Le Suicide* (1897/1951), Durkheim reviewed research linking suicide and imitation but found no evidence for its impact on the social suicide rate. Phillips (1974) reinvigorated the debate, citing "inconclusive and contradictory" results from prior research (p. 340). Through the use of evidence from British and American statistics, he determined that there was

an increase in suicide after the publication of newspaper stories of prominent suicides that was "probably due to the influence of suggestion on suicide" (Phillips, 1974, p. 341). Such influence has become known as the Werther Effect.

While the Werther Effect may explain some suicide contagion, suicide clusters also appear—particularly among young people. Research has considered the effect of media exposure on suicide rates, particularly for vulnerable young people (Gould, Jamieson, & Romer, 2003; Gould, Wallenstein, & Davidson, 1989) with the association between non‐fictional media exposure of suicide and actual suicide behaviour now well demonstrated, and determined as causal in some cases (Pirkis & Blood, 2010). The research literature supports that the suicide death of a young person can be associated with elevated suicide ideation and suicide attempts among peers (Feigelman & Gorman, 2008). Where such deaths are reported in the media there is often a degree of sensationalism—terms such as cluster and contagion are used interchangeably, with little reliability (Arensman et al., 2013; Gould et al., 1989). One such example is that of the sensationalist reporting of supposed suicide clusters in Bridgend, Wales in 2008 (Jones et al., 2013).

Joiner (1999) argued that clusters and contagion were two quite distinct entities. He described a cluster as referring to the "factual occurrence of two or more completed

or attempted suicides that are non-randomly bunched in space or time…[which]…implies nothing about *why* the cluster came to be" (Joiner, 1999, p. 89). Joiner differentiated two types of clusters. Point clusters refer to where and when people who die by suicide might be "relatively contiguous in both space and time" (1999, p. 90); and mass clusters refer to media-related phenomena for which evidence was "weak or equivocal" (1999, p. 92). Whilst not ruling out contagion, defined as "the transmission of suicidality from one victim to another" (Joiner, 1999, p. 90), as influencing clusters, Joiner felt that the definition of contagion was vague and defied analysis in terms of his ITS. Joiner considered it more likely that people who are vulnerable to suicide may cluster together: they form "relationships assortatively" (1999, p. 91) and this occurs well before the occurrence of any suicide stimulus. However, should such members of the cluster experience negative life events, including the suicide of one member of the cluster, then all members are at increased risk.

Young people can cluster together and form assortative relationships in a number of situations that can result in suicidal behaviour. One example is within schools. In 2013, Swanson and Colman reported on a Canadian longitudinal study which investigated suicidal thoughts and behaviours amongst young people aged 12 to 17 years and included a two-year follow-up. Respondents were asked whether they

knew anyone in their school who had died by suicide and if they themselves had seriously considered taking their own life. By ages 16 to 17, over 24% of respondents reported a schoolmate's suicide; over 20% reported personally knowing someone who died by suicide. Those exposed to suicide at school had a higher risk of both ideation and attempts than those who were not exposed. The risks were increased in younger age groups and suicide exposure still had measurable effects two or more years later. However, for those who reported a schoolmate's suicide, personally knowing the friend who died "did not predict suicidality outcomes" (Swanson & Colman, 2013, p. 7), suggesting any level of exposure to peer suicide can result in risk. A second example of assortative relationships increasing risk for suicidal behaviour is the clustering of young people within smaller communities. A study by Bernburg and colleagues (2009) investigated community household poverty and its effect on adolescent suicidal behaviour. The adolescents were school students with dense personal contacts who were dependent on their small school communities for peer support, status and leisure. The authors found that household poverty resulted in a greater likelihood of adolescents associating with others who were suicidal and that suicidal behaviour spread through personal contact amongst peers with suicide suggestion as the "focal theoretical mechanism" (Bernburg et al., 2009, p. 386).

Early studies about suicide clusters were based predominately on anecdotal reports, with the view that these generally occurred with young people (Gould et al., 1989). The percentage of youth suicides occurring in clusters was estimated to be between 1% and 2% (but sometimes up to 13%) and was more common in young people, and significantly higher than any other group (Gould et al, 2003). Contagion mechanisms, such as imitation (of the behaviour) and identification (with the person), were described as possible explanations for the occurrence of suicide clusters (Gould et al., 1989; Gould, Wallenstein, Kleinman, O'Carroll, & Mercy, 1990). The lack of a "systematic surveillance or reporting system of suicide clusters" (Gould et al., 1989, p. 19) was acknowledged, as was the lack of any clear operational definition of what constituted a suicide cluster (Cheung, Spittal, Williamson, Tung, & Pirkis, 2013; Larkin & Beautrais, 2012).

Arensman and colleagues (2013) attest to the growing public and professional interest in the clustering and contagion of suicidal behaviour, but caution that there still remain methodological issues regarding definitions and techniques to assess spatio-temporal aspects. These authors maintain the view that clusters consist of two different types: mass clusters and point clusters. Mass clusters are commonly defined as a temporary increase in the total frequency of suicides in an entire population relative to the period immediately before and after the cluster

(Arensman et al., 2013). Mass clusters are typically associated with high-profile celebrity suicides that are reported and disseminated in the mass media (Haw, Hawton, Niedzwiedz, & Platt, 2013). On the other hand, point clusters are a temporary increase in the frequency of suicides within a small community "relative to both the baseline suicide rate before and after the point cluster and the suicide rate in the neighbouring area" (Arensman et al., 2013, p. 11). Suicide contagion is described as suicidal behaviour that facilitates the occurrence of subsequent suicidal behaviour either directly (via contact or friendship with the person who died) or indirectly (via the media) with those who are part of an at risk population. This population is more vulnerable if they are in closer geographical and psychosocial proximity (Arensman et al., 2013).

More recent developments have seen sophisticated analysis methods applied to the study of suicide clusters. These methods used Geographic Information Systems software, such as SaTScan (Arensman et al., 2013), and applied real-time data about suicide, particularly suicide occurring in close temporal and geographic proximity. The application of such methods has challenged the long-standing assumption that suicide clusters predominantly involve young people. For example, Larkin and Beautrais (2012) found that over an 18-year period, 15 distinct suicide clusters accounted for 122 deaths in New Zealand. This was 1.3% of all suicides over the

period of the study. About half of those who died, and were considered part of the cluster membership, were younger than 25 years. The authors concluded that people who died in suicide clusters were not a homogeneous group solely comprising vulnerable and impressionable young people, but were more likely to be distinctly different groups. A similar conclusion was also derived from a study in Wales (Jones et al., 2013) using SaTScan and Space Time Permutation Scan Statistics (STPSS) to investigate media-hyped speculation of a suicide epidemic of young people in the town of Bridgend. This study was also broadened to identify possible clusters over a 10-year period in Wales. Results initially found no evidence of temporo-spatial clusters in young people (15-34 years) until a broader definition of suicide was used that included possible suicides (deaths from poisoning and drowning deemed accidental in coronial narrative verdicts). These broader parameters found statistical evidence for a cluster that comprised 10 deaths of people aged 15-34 years in Bridgend. However, over the 10-year period only 0.78% of possible suicides in this age group were identified as being cluster-related. Arensman and colleagues (2013) used the Suicide Support and Information System (SISS) developed in Ireland and combined multiple sources of descriptive information together with SaTScan to investigate suicide cases between 2008 and 2012. Two clusters were identified. The first cluster comprised mostly men (93%),

with the majority (62%) aged between 45 and 54 years of age. In the second cluster, just over half were men with the majority aged between 30 and 54 years of age.

These recent studies using advanced analysis methods do not rule out the possibility of suicide clusters occurring for young people, only that clusters are rare (Haw et al., 2013) and not necessarily confined to young people. Whilst it is still considered difficult to predict when and where a suicide cluster might occur (Cox et al., 2012), there seems to be clearer evidence that suicide contagion remains a risk for young people (Ho et al., 2000; Swanson & Colman, 2013).

Youth suicide in Australia

Australia experienced an epidemic rise in suicide from the 1970s up to the late 1990s, particularly with young men (Page et al., 2011). This prompted a Commonwealth Government response and resulted in Australia's first National Youth Suicide Prevention Strategy (Australian Institute of Family Studies, 1999). Australia then experienced a reduction in youth suicide (people aged between 15 and 24 years) between 2001 and 2010. However, it is uncertain whether the Youth Suicide Prevention Strategy was the reason for this reduction (Mitchell, 2000; Page et al., 2011).

In 2012, 338 young people aged up to twenty-four years died by suicide in Australia (Australian Bureau of Statistics, 2014). Between 2003 and 2012 the suicide rate for males aged between 15 and 24 years reduced from 18.2 to 13.6 deaths per 100,000. Over the same period, the rate for females aged 15 to 24 years, increased from 3.7 to 7.3 deaths per 100,000 (Australian Bureau of Statistics, 2014). Young males were three-times more likely to die by suicide than females (Australian Institute of Health and Welfare, 2011). While it may account for a small proportion (1.7%) of all deaths in Australia across all age groups, suicide accounts for about 28% of all deaths among young males aged 15 to 24 years, and up to 32% of all deaths among females in the same age group (Australian Bureau of Statistics, 2014). This is consistent with international data that ranks suicide in the top three leading causes of death among adolescents and young adults (Young et al., 2012).

Whilst statistically small, youth suicide rates represent a high proportion of young people dying at an age when they should be experiencing optimal levels of health, family/social/community engagement, and increasing economic productivity. The human tragedy of suicide has far-reaching effects on families, friends and communities; this is intensified with the self-inflicted deaths of young people. Suicide among young people in Australia has been identified as a serious national public health issue (Gilchrist & Sullivan, 2006a; NSW Department of Health, 2010;

Suicide Prevention Australia, 2010b). Concern about the high proportion of deaths attributed to suicide in young people, reflected in Government and non-Government policy documents and publications, is also shared by young people themselves. In a large national survey conducted by Mission Australia in 2009, young people aged 11 to 24 years ranked suicide (26.8%) as their second top issue of concern (Hampshire & Di Nicola, 2011).

There is also increasing concern around suicide amongst child and early adolescent age groups (McNamara, 2012). It is only since 2013 that the ABS commenced reporting on suicide deaths of children younger than 15 years of age. These figures have always been included in the ABS' total reporting of suicide, but never as a separate age group. The gaps in reporting are due partly to reluctance to publicly report suicides of children younger than 15 years, but also coronial concern about children's capacity to fully understand the finality and intent of death (Commission for Children and Young People and Child Guardian, 2009). The ABS (2014) acknowledges that child suicide death is an extremely sensitive issue with actual numbers influenced by coronial reporting practices and differences in courts across jurisdictions. This suggests that care is required with interpretation, and that the stated number of deaths may not be accurate.

The ABS (2014) aggregated the numbers of children younger than 15 years of age who died by suicide for the years 2008 to 2012 to give a total of 57 deaths over this period. Whilst this number is small, it is significant in terms of the proportion of all deaths within this age group. Of these 57 deaths, 15 (26.3%) were Aboriginal and Torres Strait Islander Australians (Australian Bureau of Statistics, 2014). The Queensland Commission for Children and Young People and Public Guardian (2014) reports that, from 2012 to 2013, suicide was the leading external cause of death for children aged 10 to 14 years. The Commission has also expressed concern that there has been a gradual increase in the number of these child suicides, and that male and Aboriginal and Torres Strait Islander children are over-represented in the figures (Australian Institute of Health and Welfare, 2011; Robinson, Silburn, & Leckning, 2011).

Rural youth suicide in Australia

Rural Australia has a higher overall rate of suicide compared to urban areas (NSW Department of Health, 2010); this is particularly evident among adolescent and young males in rural or remote areas (Caldwell, Jorm, & Dear, 2004). Indeed, male youth suicide rates in rural areas are estimated at almost twice that of metropolitan areas (National Rural Health Alliance, 2009a). The suicide death rate for young people aged 15 to 24 years in remote and very remote areas of Australia is three-

times higher than that of major cities (Australian Institute of Health and Welfare, 2011). The determination of the true intent of some deaths and underreporting of suicides due to concerns of stigma and confidentiality (De Leo et al., 2010), suggest that the actual rate in rural Australia is considerably higher than the number of registered suicides (Suicide Prevention Australia, 2008).

A study by Page and colleagues (2007) analysed ABS' urban and rural suicide data for male and female youth populations for the period 1979 to 2003. Small numbers of specific population groups can produce random variation in suicide rates, so the data was aggregated into periods of five years. The suicide rate for young males in rural, regional, and remote areas was found to diverge significantly (increase) compared to the rates in metropolitan areas over the time of the study. Specifically, during the period 1999-2003, the male rates in metropolitan and rural areas decreased, but increased in remote areas. Page and colleagues (2007) speculated that socio-economic status, migrant composition, gender differences and changed economic conditions might be responsible for the difference in rates. A similar pattern was found for females aged 15 to 24 years in the period 1999-2003. Prior to this, suicide rates were higher in metropolitan areas but these converged significantly with increased rates in rural and remote areas. The authors concluded that there was "a diverging trend attributable to a continued increase in suicide in

remote areas alongside a decline in suicide in large rural and metropolitan areas" (Page et al., 2007, p. 451). These results are consistent with the view that the suicide rate in Australia, particularly for rural males aged 15 to 24 years, tends to rise with increasing remoteness (Boyd, Aisbett, Kelly, Newnham, & Newnham, 2006).

An apparent anomaly is the relationship between mental health and suicide—prevalence levels of psychological distress or mental disorders, especially in males, are not significantly different between young people living in major cities and those living outside major cities (Australian Institute of Health and Welfare, 2012). There are likely a number of explanations for this. First, rural young people who are in need of help for mental health problems often experience a lack of services and available information, particularly in remote areas (Suicide Prevention Australia, 2010b). Second, symptoms of mental distress may not be recognised and specialist support not sought, and ignorance about the role and value of mental health services results in a lack of consultation (Judd et al., 2006; McColl, 2007). Third, stigma associated with mental health problems and suicide (Suicide Prevention Australia, 2010a), which is more pronounced in rural Australia, can impact on the willingness and ability of people to seek help (McColl, 2007). Fourth, people living in rural communities can also be subject to the "rural paradox of proximity and distance" (Boyd et al., 2006, p. 3.), whereby despite physical distance, people have

intimate knowledge of each others' lives, and this can silence mental health difficulties as rural residents limit assistance and social support to those diagnosed with mental illness (Boyd et al., 2006). Lastly, young people are particularly concerned about the confidentiality and anonymity of services (NSW Centre for the Advancement of Adolescent Health, 2005), and may resist attending if they suspect that personal information might be disclosed (Boyd et al., 2006). These factors can all result in higher rates of suicide irrespective of similar rates of mental disorders. It is also likely that higher rates of rural youth suicide are influenced by the disproportionately higher Indigenous population in remote areas of Australia (Page et al., 2007), given the huge disparity of Indigenous suicide when compared with the non-Indigenous population.

Australia experiences unique challenges across rural and remote areas, and these can also impact on young people and suicide. Categories such as 'rural' and 'remote' imply common shared characteristics whereas in reality there is considerable variation both between and within these locations (Judd et al., 2006). Different rural sub-populations may respond uniquely to particular environmental characteristics and to other structural factors (Page et al., 2007).

Notwithstanding the above, there can be major shortages of professionals and skilled labour in rural areas, with relatively high levels of unemployment. The drought (during, recovery from, and post-impact), plus other structural shifts in the economy, also impact on unemployment. The impact of drought is also a significant source and cause of mental stress in rural communities. This, along with service withdrawal and government restructuring (McColl, 2007), are major risk factors for suicide given the resultant financial pressures, social isolation and family strain. Restricted social and career opportunities for young people can result in migration between rural centres, which disrupts family and supports and can isolate young people. Young people's use of alcohol and other drugs is also higher in rural areas (Australian Institute of Health and Welfare, 2008), which has been found to contribute to impulsivity and increased risk of suicidal behaviours (Pompili et al., 2010). While alcohol and drug use can often be considered within the realm of normal adolescent development and experimentation (Muir et al, 2009), this appears to be more extreme in rural areas with long lasting negative health implications. Furthermore, the accessibility of firearms in rural areas can contribute to the lethality of youth suicide attempts (Kölves et al., 2012; Suicide Prevention Australia, 2010b), even though firearms are no longer the most common method of suicide in Australia.

This section has reviewed literature relevant to suicide, particularly to youth suicide and rural youth suicide, in Australia. The next section reviews the literature relevant to suicide bereavement and the issues that people bereaved by suicide may experience. The final section of this chapter focuses on the suicide bereavement experience of adolescents, and particularly research with Australian rural adolescents, which is largely absent in the literature.

Suicide Bereavement

Death by suicide is sudden, sometimes violent, and mostly unexpected. It is a catastrophic event with traumatic consequences for those bereaved. Every death brings with it grief and loss for those who are bereaved; however, a death associated with violence and trauma can bring extra burden. As Raphael and colleagues (2005) suggest, the grief associated with this type of loss requires special understanding, empathy, and time. The term 'postvention' was coined by Shneidman over four decades ago to describe interventions that could facilitate the grieving process with people affected by a suicide death (Jordan & McIntosh, 2010). Since then, increasing focus has been directed to research and the types of interventions required by people bereaved by suicide (Andriessen & Krysinska, 2012).

Individuals bereaved by suicide are not a homogenous group (Wojtkowiak, Wild, & Egger, 2012). Further, exposure to suicide does not necessarily mean a significant negative impact (Jordan, 2008). As such, everyone may not require postvention services. However, it cannot be prescriptive for those who do, and needs to empower people to find their own path through their grief and bereavement (Grad, Clark, Dyregrov, & Andriessen, 2004). This view raises a number of significant questions:

- How is someone determined to be bereaved by suicide?
- What are the distinct differences, if any, in the responses between those bereaved and those not bereaved by suicide?
- Does this experience differ depending on the relationship to the person who died, and what other factors are in play?

Such issues have been grappled with in the literature since Shneidman first focused attention on the subject of bereavement. Cerel and colleagues (2013) state that identifying who is exposed to suicide death and, within this group, who is negatively affected by the death is still not well understood. Jordan and McIntosh (2011) suggest that the ways in which the act of suicide is explained also informs how suicide postvention activities are conducted. The following section discusses

some of the definitional and methodological issues associated with suicide bereavement.

The nature and extent of grief experienced after a suicide has been the subject of debate in the literature (Jordan, 2008). Do people bereaved by suicide experience grief differently to others who are bereaved following other types of traumatic death, such as homicide or a natural disaster? Jordan and McIntosh (2011) discuss that, although bereavement after suicide shares many aspects of the grief response following other types of bereavement, people bereaved by suicide often show high levels of distress in several domains of functioning. This includes elevated risk of suicide and problematic grief experiences. Other facets that may be unique to, or influence, suicide bereavement may include:

- *Guilt* expressed as a bereaved person questions why the person decided to take their own life and what could/should have been done to prevent the suicide.
- *Shame and stigma* relate to mourning which can become a profoundly isolating experience, which, in turn, has a major impact on family and friends. Distortions in communication can occur within families and social networks including the development of blame for the suicide and a perceived need to keep the suicide secret with social ostracising and self-

isolation. People bereaved by suicide experience significant stigma which can sometimes consist of overt responses from others, or ambiguity within the community where members may not know what to do or how to respond. Those bereaved by suicide can also 'self-stigmatise' and avoid contact with others due to their feelings of guilt or shame (Rusch et al., 2009).

- *Rejection and abandonment* result from the ambiguity felt by those bereaved by the suicide death. The multi-determined causes of suicide can lead to uncertainty for those bereaved: did the person choose to die; was it due to mental illness; were there other life circumstances? These, often unanswerable, questions result in feelings of rejection, anger, and abandonment.
- *Horror and trauma* where a traumatic death such as suicide can result in the experience of horror and reliving of intrusive memories and behaviours that can be associated with posttraumatic stress disorder (PTSD). Those bereaved can also ruminate about the suffering of the person who died and this can be intensified if they witnessed the death or found the body.

Who is suicide bereaved?

Whilst there are potentially a number of grief responses for people bereaved by suicide, there is a lack of consensus in the literature about the definition of someone bereaved by suicide (Andriessen & Krysinska, 2012). Two critical questions are:

(1) Who is affected following a suicide?

(2) How broad is the impact of suicide bereavement?

The literature commonly equates the earliest count of those bereaved by suicide with Edwin Shneidman. A number of authors (for example, see Andriessen and Krysinska, 2012, and Jordan and McIntosh, 2011) report that the claim made by Shneidman (1973b)—for every suicide, there are at least six survivors—was actually a guesstimate. However, this has continued to be repeated in the literature as an established fact. Andriessen (2009) does acknowledge that an objective count of the number of people bereaved is hindered through the lack of a consensus definition as well as an appropriate assessment strategy.

An attempt to identify the number of people exposed to suicide was undertaken by Crosby and Sacks (2002). A telephone survey was conducted to determine the number of people older than 18 years exposed to the suicide of someone they knew in the preceding 12 months, including the relationship with the person who died, and whether exposure was associated with suicide ideation or behaviours by the

respondent. Approximately 7% knew someone who had died by suicide. The authors calculated that this represented 425 adults for each suicide death in the USA over the previous 12 months. Males, those of a younger age and who had never married, had greater exposure, typically a friend or acquaintance had suicided. There was a greater likelihood that exposure was also associated with suicide ideation and behaviour, but this was not statistically significant. It was also not possible to determine whether the type of relationship influenced suicidal behaviour. However, the authors concluded that the quality of the relationship was probably the most meaningful factor. While the limitations of this study were associated with the nature of telephone surveys and response rates, and hence the representativeness of the results, the study did identify a much broader scope of exposure than prior studies had done. However, the study was not able to equate suicide exposure with an operational definition of bereavement to enable a more accurate estimate of the number of people significantly impacted following a suicide.

Jordan and McIntosh (2011) argue that the problem of definition is related to two simplistic assumptions in the literature: 1) all suicides are more or less the same in their impact; and, 2) that the degree of impact is mostly a function of the kinship closeness to the deceased. Those bereaved by suicide include immediate family,

friends, work colleagues, and other professionals (such as psychologists and counsellors) who may have worked with the person before they died. For this reason, Jordan and McIntosh proposed that a more precise definition of someone bereaved by suicide was "someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person" (2011, p. 6). Such a definition helps the focus of suicide bereavement but still lacks operational meaning. For example, what is a high level of distress and how long is a considerable period of time?

Berman (2011) recently proposed that a more functional definition for people bereaved by suicide: someone who is "intimately and directly affected by a suicide" (p. 111) and would self-define as being bereaved after the suicide death of another person. Berman operationalised this definition using survey data completed by members of a suicide survivor association in the United States. Respondents were asked their gender and relationship to the person who died by suicide. Relationship categories included spouse/partner, parent, child, sibling, friend, and other (for example, grandparent). Respondents were also asked the age of the person who had died by suicide, and to estimate of the number of persons they considered were directly affected (by category), and the estimate of the frequency of contact (daily, weekly or less frequently) with the person who died. Parents of children who had

died estimated that more than 80 individuals would meet the definition of someone bereaved by suicide. For the death of a partner or spouse, the number was about 60; for siblings or friends, the estimated number was 45 to 50. When estimates of people bereaved were limited to members of the nuclear family, a figure of just over five people resulted, which was extremely close to Shneidman's original estimate. When frequency of contact was added, this figure increased to seven people per suicide. Again, there are limitations with this study. The small sample size (187 participants) consisted of those who had already self-identified as bereaved by suicide, which problematises the representativeness of the results. Additionally, respondents were sampled about their interpretation of others who they felt were affected and this may or may not have been accurate. Despite these limitations, the data suggests that there is no specific tally for people bereaved by suicide. Instead, there is considerable variation and this seems to depend on the bereaved person's age, relationship and frequency of contact with the person who died.

To address the issue of exposure to suicide, self-report of significant affect and subsequent problems, Cerel and colleagues (2013) undertook a random digit dial study of adults in Kentucky (USA). Participants were asked a series of questions that included the experience of knowing someone who attempted or died by suicide over their lifetime. Forty per cent of the total sample reported they knew

someone who died by suicide. Nearly 20% of the total sample claimed they were affected by a suicide death, and self-identified as someone bereaved by the suicide. This suggests that up to half of those exposed to suicide will feel a significant impact from the death. While relationship status did not predict those who identified as bereaved, closeness of the perceived relationship with the person who died seemed to differentiate those who felt significantly impacted by a suicide from those who did not. Those who reported feeling very close were more likely to feel impacted. A younger age was also associated with reporting impact from the death.

A different approach to studying people bereaved by suicide was undertaken by Schneider and colleagues (2011). They explored the relationships between the emotional reactions of those bereaved and the socio-demographic and psychiatric diagnoses of those who had died. Using a semi-structured interview, key informants—comprising relatives and close friends—were asked how the deceased's death affected them, and whether they had experienced emotions such as sorrow, depressed mood, and guilt. The authors concluded that the older age of the deceased was associated with reduced incidents of emotion that caused distress in the lives of the key informants, and that "perhaps suicide becomes more accepted and understandable with increasing age of the deceased" (Schneider et al., 2011, p. 123).

More recently, Cerel and colleagues (2014) considered issues in language and definition important in determining who is bereaved by suicide in order to advance the field of postvention. These authors proposed a continuum of survivorship that considers people exposed to suicide, affected by suicide, then suicide-bereaved short-term and, suicide-bereaved long-term. The identification of such categories can assist both research and clinical interventions. However, more works need to be undertaken to determine "if these new definitions make sense based on the way people view themselves" (Cerel et al., 2014, p. 6).

The literature continues to expand with studies that attempt to better determine the numbers and categories of those bereaved by suicide. This research is important because it builds evidence for public health support and also shapes the nature of interventions that may be required. The experience of people grieving a suicide death is a unique form of bereavement and research is required about their personally perceived needs, and "how this perception may vary in different societies" (Dyregrov, 2011, p. 310).

Suicide bereavement, prolonged grief and suicide risk

Studies undertaken with different groups of people bereaved by suicide point to certain shared experiences that include prolonged grief (described interchangeably

as traumatic or complicated grief), increased suicide risk, and increased risk for other psychiatric morbidity. Prolonged grief has been proposed as a new and distinctive psychiatric disorder that can occur in response to significant loss through death (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). Whilst most bereaved people will adapt to the loss of a significant other, an identifiable minority will experience chronic, disabling, and pathological grief (Prigerson et al., 2009).

Despite evidence to support the occurrence and risk of prolonged grief, as well as validation of the criteria for the disorder (Prigerson et al., 2009), the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) does not code prolonged grief as approved diagnostic criteria. It is, however, included as a condition for further study under the title *Persistent Complex Bereavement Disorder,* with the recommendation for additional research to warrant future inclusion.

Prolonged grief is characterised by a number of features, including: an intense longing and yearning for the person who died; and bitterness about the loss with the wish that life could return back to the time before the death. They may also ruminate and be unable to concentrate, resulting in feeling disconnected from others, which exacerbates alienation and social isolation. Recurrent intrusive

thoughts make it difficult for these bereaved in particular to move beyond an acute state of mourning: lives seem to lack meaning and purpose without the deceased. There is a difficulty to move on with life, as the ability to form other interpersonal relationships and engage in potentially rewarding activities is restricted. These features have been developed into standardised criteria (Prigerson, Vanderwerker, & Maciejewski, 2008), which distinguish prolonged grief from major depressive disorder (Prigerson et al., 2009).

The literature suggests that about 10% to 20% of people bereaved by suicide may develop prolonged grief (Young et al., 2012). In contrast, about 15%, separate to the 10-20%, will experience symptoms of distress and major depressive disorder (Bonanno, 2004). These individuals will experience impaired daily functioning, increased rates of psychiatric comorbidity, and a higher risk for suicide ideation and behaviour.

It is not clear from the literature whether all categories of people bereaved by suicide (for example, spouses, children, siblings, friends, and colleagues) are equally at risk of prolonged grief following suicide. What does seem apparent from the literature is that, independent of the specific relationship someone might have to the deceased, the closeness of that relationship has some bearing on this risk. For

example, Mitchell and colleagues (2004) assessed 60 adults within one month of the suicide death of a family member or significant other. They found significant differences in prolonged grief between those who were closely related, and those distantly related, to the person who died. Adults who were closely related experienced nearly twice the level of prolonged grief compared to those who were distantly related.

Prolonged grief is associated with higher risk of suicide, particularly for those bereaved by suicide (Jordan, 2008). Increased risk of suicide among people bereaved by suicide has been found in a number of studies (Pittman, Osborn, King & Erlangsen, 2014). A telephone survey conducted by Crosby and Sacks (2002) found that those exposed to another's suicide were more likely to experience suicide ideation, develop a specific plan, and made a suicide attempt. Agerbo (2005) described a case-control design to study adults who died by suicide matched to a random sub-sample of 20 people of the same gender and age. The study found that the risk of suicide increased if a spouse had been admitted for treatment at a psychiatric hospital. Spousal loss by suicide increased suicide risk in both males and females—males experienced a nearly three-times higher suicide risk.

Using the same case-control design as Crosby and Sacks, Qin and Mortensen (2003) studied the ways in which having children influenced parents' suicidality in Denmark. Suicide deaths between 1981 and 1997 were randomly matched to controls and detailed information about children was extrapolated. This information consisted of the number of children, age of the youngest child, childhood psychiatric illness, and child deaths. For women, having children resulted in a significantly decreased risk of suicide; a young child was particularly significant in preventing suicide predominantly among women. However, having a child with psychiatric illness elevated suicide risk in the parents. There was also an increase in parental suicide risk, particularly for mothers, if an adult child died by suicide. The authors concluded that, if a child died by suicide, parents would likely experience "strong feelings of guilt, responsibility, shame, stigmatization, and rejection" (Qin & Mortensen, 2003, p. 802). These types of experiences may be influential in subsequent parental risk of suicide because grief recovery is more difficult "particularly for mothers of young deceased adults" (Qin & Mortensen, 2003, p. 802).

To summarise, the quantitative evidence is equivocal about whether bereavement following suicide is different to bereavement after other forms of death. People bereaved by suicide may not differ significantly from other bereaved groups

regarding general mental health, depression, PTSD symptoms, and anxiety (Sveen & Walby, 2008), although they may have higher rates of prolonged grief and risk of suicide (Schneider et al., 2011). In addition, they can also experience many other emotions during the grieving process, such as lack of energy, guilt, abandonment and anger (Jordan, 2001; Sveen & Walby, 2008). These emotions can lead to disturbances in everyday life but occur less frequently with the increasing age of the person (Schneider et al., 2011).

In contrast, qualitative studies tend to identify thematic issues likely to be more prominent and intense following a suicide compared to other forms of loss (Jordan, 2001, 2008). Qualitative studies have also identified that searching for reasons and wanting to make sense of the death impose a greater burden on those bereaved by suicide. Those bereaved face their own struggle to understand the reasons behind the death and this is coupled with a lack of understanding, and often questioning, by others (Bell, Stanley, Mallon, & Manthorpe, 2012). This lack of understanding can be intensified when (or if) people bereaved by suicide identify they anticipated, or had prepared for, the suicide death of a family member (Maple, Plummer, Edwards, & Minichiello, 2007). This proposition's lack of fit with the current social discourse about suicide as an unexpected loss means that many people can be silenced from talking about their loss out of shame, guilt, and blame (Maple,

Edwards, Plummer, & Minichiello, 2010). In addition, parental suicide can often be the culmination of a highly dysfunctional family life in combination with unresolved previous trauma (Ratnarajah & Schofield, 2008). This can leave those bereaved by suicide both ostracised and overtly blamed (Cerel, Jordan, & Duberstein, 2008) by others who know little of the family background and circumstances, irrespective of whether those bereaved expected the death and had less experience of grief following the death (Wojtkowiak et al., 2012).

Suicide bereavement and young people

To date, research dealing with youth suicide has mostly focused on ameliorating known suicide risk factors to reduce the number of young people who die (Department of Health and Ageing, 2007). Yet those most intimately affected by the suicide death of a young person, such as parents, other family members, and friends, are largely ignored. Previous or recent significant loss, are major factors contributing to suicide (Pittman et al., 2014). This is particularly so with young rural Australians; however, "the mechanisms of bereavement following suicide remain largely unexplored and empirically understudied" (Suicide Prevention Australia, 2009, p. 2).

While the importance of continued suicide prevention activities cannot be overstated, increasing research has established that people bereaved by suicide are also at risk of a range of mental health problems including: depression, anxiety, poor coping, prolonged grief, self-harm, and suicide (Pitman et al., 2014). It is essential that people who experience these negative outcomes after a suicide are offered appropriate interventions. However, scant research and interventions have been undertaken with young people who are bereaved by suicide. The available research is largely hampered by methodological and practical challenges meaning "the sequelae, determining factors, and experiences of those bereaved by suicide are not well known" (Hung & Rabin, 2009, p. 782).

Young people who are bereaved by suicide can experience difficulty with emotional regulation. Most adolescents can master the basic skills that allow them to handle strong emotions, but these skills can be challenged in the face of suicide (American Foundation for Suicide Prevention and Suicide Prevention Resource Center, 2011). Young people may not yet have learned how to recognise complex feelings or physical indicators of distress, so their ability to appropriately experience and express intense emotions such as grief and fear is compromised. This is exacerbated when social contexts are already disrupted and young people might struggle to

manage feelings associated with loss and grief (American Foundation for Suicide Prevention and Suicide Prevention Resource Center, 2011).

The majority of published studies that consider the impact of suicide tend to focus on family research (Moore, Maple, Mitchell, & Cerel, 2013) on the basis that suicide occurs in families and the aftermath within families is an important step to determine what assistance is needed (Cerel et al., 2008). Studies that consider the impact of suicide on young people also tend to be from the family perspective and consider issues for siblings, or the effect of parental suicide death on children or young adults. For example, Brent and colleagues (1993) found higher levels of depression and grief in the siblings of teenage suicides. However, at longitudinal follow-up, fewer long-term psychological sequelae were found, suggesting something about the connection to family and the resultant expression of grief that leads to better resolution (Brent, Moritz, Bridge, Perper, & Canobbio, 1996a).

Dyregrov and Dyregrov (2005) investigated two groups of siblings who had lost a brother or sister to suicide. The first group was aged between 15 and 20 years and the second group between 21 and 43 years. Both groups completed questionnaires; a smaller sub-set of each group participated in an in-depth interview. Siblings identified feelings of blame, stigma, and rejection. They often felt forgotten as their

parents struggled with their own grief. Similar to the findings of Brent and colleagues (Brent, Perper, Moritz, Liotus, et al., 1993), younger siblings experienced the most difficulties. A likely mediator here was that older siblings often had the support of others such as their own family, and were not as reliant on parents for support. Over time there was increased insight and maturity for most of the siblings, which they identified had resulted from their experience.

A meta-analysis undertaken by Geulayov and colleagues (2012) focused on 28 studies that investigated the impact of parental suicide on children. These authors found that children exposed to parental suicidal behaviour were at increased risk of these same behaviours. Maternal suicide and younger age of the child increased the risk of suicidal behaviour as well as depression. Similarly, a study by Wilcox and colleagues (2010) also found that children who lost a parent to suicide during either childhood (0-12yrs) or adolescence (13-17 years) were three times more likely to die by suicide compared to children whose parents were living. Again, maternal suicidal behaviour and younger age at exposure were associated with larger effect estimates. Young adults who experienced parental suicide death were not at increased risk. Younger age bereavement was also associated with higher risk of hospitalisation for drug use disorders and psychosis.

In addition, children and adolescent survivors of parental suicide show increased depression, anxiety and behaviour problems when compared with non-suicide bereaved children (Cerel & Roberts, 2005). Adolescents exposed to suicide attempts and suicide death by family members are likely to be engaged in behaviours that put them at risk of future problems including marijuana use, binge drinking, suicide ideation and attempt, and violence toward others (Cerel & Roberts, 2005).

Despite the increasing awareness of the issues and needs of people bereaved by suicide, young people who have lost a friend to suicide are missing from the suicide bereavement literature, yet the death of a significant person during adolescence can greatly impact on relationships and development (Forward & Garlie, 2003). This limited focus on young people and their friends may be due, in part, to the historical acceptance of Shneidman's six survivors to a suicide—this presumes survivorship was limited to the immediate family, with no consideration beyond this. Cerel and colleagues (2005) argue that adolescents, particularly, are embedded in peer and social contexts within schools. As a result, the suicide of one of their peers radiates out like a wave, causing distress to close friends and ripples among those not known to the person who died. Youth suicide bereavement in relation to peers is an identified major public health issue; however, limited published research explores this (Cerel et al., 2005).

Notwithstanding the literature considering suicide contagion and young people, the earliest published studies investigating the impact of suicide on friends and acquaintances have aligned with the occurrence of a student's suicide in school and subsequent concerns for peers. Commencing with Brent and colleagues (1989) in the United States, and Hazell (1991) in Australia, these studies have respectively considered the cluster effect and the imitative effect of student suicides in schools. Brent and colleagues (1989) found that exposure to suicide resulted in elevated rates of suicidality amongst a cluster of students at school. Students who became suicidal after exposure were more likely than non-suicidal peers to be depressed and have had past episodes of depression and suicidality. Close friends were found to manifest suicidality at a lower threshold to others who were less close to the person who had died. Hazell (1991) reported on interventions undertaken at three secondary schools following student suicide death. The interventions were focused on a rapid response to the prevention of imitative suicidal behaviour and directed at students perceived to be at risk. These studies highlighted the need for a formalised approach to responding to suicide in a school, but also raised a number of issues including how to identify, and determine the most appropriate, students for intervention. Hazell (1991) stated: "The number of students presenting with later suicidal behaviour who had not attended the intervention suggests that the parameters used to identify students were inadequate" (p. 341).

A later study by Hazell and Lewin (1993) investigated exposure to suicide attempts and suicide death among a cohort of secondary school students. The students rated their proximity to the suicide attempt or death as: no exposure, same school, class, friendship group, boy/girlfriend. This proximity was categorised into three groups: high exposure, comprising those students who rated themselves as friendship group, personal friend and boy/girlfriend; low exposure, consisting of same class and school; and, no exposure. Exposure to suicide attempts was found to result in greater disturbed behaviours than exposure to suicide death. However, friendship with an adolescent who attempted suicide or died by suicide was a marker of greater vulnerability to emotional problems, including suicide, suggesting the assortative nature of such relationships (Joiner, 1999). Hazell and Lewin speculated that some of the young people who were placed into the high exposure group–on the basis of their self-identification–may have been part of the low exposure group but exaggerated their proximity to the person who died. The authors suggested that this inclusion might have reduced the apparent deviance of the group.

Some studies have found limited or no evidence for exposure to peer suicidal behaviour and subsequent risk of suicide. Brent and colleagues (1996b) investigated the long-term impact of exposure on friends of an adolescent suicide compared to unexposed community controls. They found comparable numbers of suicide

attempts with both groups over the three-year follow-up period and concluded that exposure to a friend's suicide did not increase the risk of suicidal behaviour. They did, however, find that the suicide exposure group had higher levels of psychopathology. There was an initial marked increase in depression, anxiety, and PTSD at later follow-up, particularly among young people exposed to suicide and who knew about the suicide plans of their friend.

Higher rates of psychopathology had previously been found in studies by Brent and colleagues (1993), who investigated friends of adolescent suicides and found higher rates of depression. Similarly, Brent and colleagues (1994) investigated depression in 121 friends of 26 adolescents who died by suicide compared to a non-exposed control group. The exposed friends had a higher incidence of depression, particularly if they had developed a depressive disorder prior to the suicide, but there was no evidence of increased risk of attempts in the exposed group suicide victims. Mercy and colleagues (2001) compared a case population of 153 people aged between 13 and 34 years who had made an almost-lethal suicide attempt with 513 controls in a specific geographic location. They concluded there was no evidence for exposure to the suicidal behaviour of others as a risk factor for suicide attempts. However, the case subjects were more likely to be depressed, have alcohol problems, move more frequently, and have relationship issues. In fact, they found a

marginally protective association of exposure to suicide behaviour supporting a view that this might make suicide behaviour incomprehensible or inappropriate and thus potentially disinhibit its occurrence.

Other studies reported in the literature do support exposure to peer suicidal behaviour and higher rates of personal suicide ideation and attempts (for example Borowsky, Ireland, & Resnick, 2001; Brent et al., 1989; Cerel et al., 2005; Hawton et al., 2012; Ho, Leung, Hung, Lee, & Tang, 2000; Rew, Thomas, Horner, Resnick, & Beuhring, 2001). Cerel and colleagues (2005) investigated the relationship between suicidal behaviour and risk behaviour in a large sample of young people aged between 11 and 19 years in the USA. Using survey data, 15.5% of the adolescents were exposed to a suicide attempt by a peer; exposure to a peer's suicide death was reported by 3.2% of adolescents. Young people who had experienced a suicidal death of a peer were 5.4 times more likely to report suicidal ideation, 9.4 times more likely to have a history of their own suicide attempt in the last 12 months, and 3.1 times more likely to report inflicting serious injuries on others. They were also more likely to binge drink and smoke cigarettes and marijuana. The authors concluded that young people who experience a peer's suicide attempt or suicide death "should be the focus of assessment and potential intervention" (Cerel et al., 2005, p. 241). However, the correlational nature of the study data precluded stating causal effects

of exposure to suicidal behaviour in peers. Additionally, the closeness of the relationship with the peer, who either attempted suicide or died by suicide, was not determined in the study, with participant involvement based on a dichotomous question (have any of your friends tried to kill themselves during the past 12 months?).

Some large-scale studies with school-aged populations (Ho et al., 2000; Wong, Stewart, Ho, Rao, & Lam, 2005) have also concluded that young people exposed to peer suicide attempts are at greater risk of suicidal behaviour compared to those who are exposed to peer suicide death. Ho and colleagues (2000) speculated that, while both groups had high levels of psychiatric disturbance, a close relationship with someone who died by suicide increased the risk for internalising problems, whereas closeness to someone who attempted suicide carried a higher risk for externalising problems. Wong and colleagues (2005) concurred that exposure to a peer's suicide attempt increased the risk of suicidal behaviour, but that young people with pre-existing depression or suicidal ideation were at particularly high risk for engaging in suicidal behaviours when exposure to an attempt occurred. A recent large-scale study of young people exposed to the suicide of peers (Swanson & Colman, 2013) also found that exposure to suicide is a strong predicator of suicidality, but with increased risk in younger age groups. The results of this study

were aligned with Brent and colleagues (1992) in that the closest friends of someone who died by suicide did not have an increased risk of suicidality compared with acquaintances. Additionally, young people who had experienced a stressful life event were considered to be more affected by suicide exposure.

The concern for suicidal behaviour in young people following exposure to the suicide of peers is a major focus in the literature, but it is not the sole focus. Not all young people are vulnerable to manifesting suicidal behaviour following exposure to the suicidal behaviour of others—information about other characteristics is important to help guide interventions (Wong et al., 2005). Distress in young people exposed to suicide can be conveyed in a number of ways, including depression and anxiety, prolonged grief, violent behaviour, cigarette smoking, or alcohol and substance use (Cerel et al., 2005).

Melham and colleagues (2004b) reported a sample of 146 friends and acquaintances of 26 individuals who died by suicide. The friends were aged between 11 and 23 years with a mean age of 18.3 years. They completed a number of standardised measures at six months following their friend's suicide; again, between 12 and 18 months; and again, 36 months after the initial interview. The authors found that adolescents exposed to a peer's suicide were a high-risk group with increased rates

of psychiatric disorder, depression, anxiety, substance abuse, conduct disorder, and attention deficit disorder. The occurrence of prolonged grief symptoms was found to be independent from depression despite comorbidity of the two in a substantial number of subjects. Prolonged grief at six months also predicted the onset of depression and PTSD at subsequent assessment.

Mash and colleagues (2013) examined young adults aged between 17 and 29 years who had experienced the death of a close friend or sibling within the previous three years. The bereaved sample comprised 73 young people; 66 who had lost a close friend, and seven who had lost a sibling. This group was compared to a group who had not experienced a loss. Death by suicide represented 18% of all the losses experienced by this sample. The authors reported that 21% of the bereaved young adults reported prolonged grief; 39% reported mild to severe symptoms of depression that had persisted for up to three years after the loss. Complicated grief and depression was found to be higher for siblings compared to close friends. The authors concluded that adult siblings were particularly distressed due to the intensity and personal quality of their relationship; these feelings were more pronounced among close friends. While this makes intuitive sense, the difference in the sample size between friends and siblings perhaps limits the representativeness and generalisation from the results.

A longitudinal study by Feigelman and Gorman (2008) compared the responses of young people who had experienced a friend's suicide death in the past 12 months to those who had not. This was a national survey over three time periods between 1995 and 2002. Risk factors associated with suicide, such as depression, substance use, school and parental conflict, were assessed by self-report data using computer-assisted interviewing technology. Two key findings were reported. First, a friend's suicide increased suicidal thinking and suicide attempts, as well as higher rates of depression in the first year following the loss. Heightened suicidality did not continue in ensuing years. Second, recently occurring events such as current depression, delinquent conduct, low self-esteem, and drug use were more likely to stimulate current suicide inclinations than other events, including suicide exposure, which had occurred in the past. A major limitation in this study was no differentiation between whether friends were close or remote, and that having only a single category of friend might explain "the failure for having this traumatic event exact an enduring negative impact on one's psychic life" (Feigelman & Gorman, 2008, p. 192).

Despite all the negative outcomes determined to result from the suicide bereavement of a friend, the majority of published research relevant to young people's exposure to the suicidal behaviour of a friend consists predominantly of

quantitative investigations. The studies by Brent and colleagues (1993, 1996a) were interview-based investigations (Cerel et al., 2005) and these consisted of standardised reports and a semi-structured interview. However, the interview undertaken was utilised to describe and gauge diagnostic and psychiatric morbidities and outcomes, rather than the actual experience of the friend/peer in relation to the suicide of their friend.

Thorough investigation of the literature uncovered limited studies using qualitative methodologies to investigate young people's experiences of their friend's suicide. Hoffman, Myburgh, and Poggenpoel (2010) reported on the lived experiences of five female adolescents aged between 17 and 22 years. Three had experienced the suicide death of a family member, while two participants had experienced the suicide death of a friend. Using a phenomenological and arts-based research approach for their inquiry, the authors found nine specific lived experiences that seemed to worsen over the weeks and months following the experience of suicide. These experiences included guilt, self-blame, depression, sub-optimal coping patterns, changed relationship dynamics, and suicidality. The authors concluded that the intensity of these experiences at times overwhelmed the young people and prolonged their grieving and healing. Whilst these experiences were considered "natural expressions of painful feelings and thoughts" (Hoffman et al., 2010, p. 7),

an obvious limitation was the small number of friends and whether their experience was different to family members.

A study by Bell and colleagues (2012) used a Psychological Autopsy approach to investigate participants who were associated with twenty students at higher education institutions who had died by suicide. The study included interviews with family, friends, higher education staff, medical records staff, and information from health professionals. The age demographics of the twelve (student) friends were not reported. The results presented focused very much on the nature of grief. Virtually all participants experienced "a sense of guilt or questioning their role or responsibility in the death; a mental torment of unanswerable questions, and sometimes of shame" (Bell et al., 2012, p. 60). The authors reported that the study provided a unique insight into disenfranchised grief, which seemed to be more acutely experienced by young people who were not immediately identified as close mourners. Disenfranchised grief is defined as grief that is not, or cannot be, openly acknowledged, publically mourned, or socially supported (Doka, 1999). This type of grief was considered in the context of students who were young and living away from home for the first time. Intense and intimate friendships often form rapidly at this particular stage of life transition; when these bonds are suddenly disrupted by

another's suicide, the results can be devastating, irrespective of the actual closeness of those in the group (Bell et al., 2012).

Bartik and colleagues (2013a) reported a qualitative investigation of ten young adults who had experienced the suicide death of a friend. The young people described alcohol consumption, binge drinking, use of other drugs, and increased (and possibly unsafe) sexual activity in their narratives, suggesting a form of compensatory coping behaviour. The experience of grief expressed was similar to the survivor guilt found in other studies (Hoffman et al., 2010; McMenamy et al., 2008). However, the guilt expressed by those who questioned their deservedness (or entitlement) to feel grief compared to others they deemed to be closer to the deceased, such as the immediate family, was unique. The authors concluded that if suicide bereaved friends avoided or denied their own grief, they might also be less likely to seek support. In the absence of healthy outlets for grief, there is greater likelihood that young people will adopt other behaviours to deal with their emotional pain.

Studies such as Bartik et al. (2013a), Maple et al. (2007), and Ratnarajah and Schofield (2008) highlight that bereavement following suicide is stigmatisi**n**g and those bereaved are often unable to talk about their experience. This effect of being

silenced has the potential to lead to long-term grief that can become disabling and, at the extreme, can lead to suicidal ideation and suicide (Maple et al., 2010). This silence, often borne out of stigma and shame, is intensified for people who live in rural locations, with young people particularly vulnerable as they are less likely to seek help and support due to help negation that can result in avoidance or refusal (Wilson et al., 2005b).

Suicide bereavement of rural young people

The higher rate of suicide for young people in rural areas also means that there is a higher rate of young people bereaved by suicide. There is, however, minimal research that investigates this, or considers whether rural suicide bereavement is different for young people compared to those who reside elsewhere. Young people, particularly in rural communities, seem to be at increased risk of suicide and suicidal behaviour following the suicide death of another young person. The specific risk in rural communities may result from the close networks formed by young people due partly to greater social proximity (Boyd et al., 2006). These denser relationships can result in heightened suicide exposure and might also relax inhibitions about suicide that can support or lead to an acquired capability for suicide (Stanley et al., 2009). More closely woven social networks can facilitate easy transmission of distress, particularly for young people who are experiencing

transitions. For example, transitions such as movement between family, schools and communities can make young people vulnerable due to weakened protective support networks (Stanley et al., 2009). Alternatively, heightened suicide risk can extend beyond those who are close to the person who died and manifest in others with more tenuous links—these others are perhaps still connected due to some association or shared characteristic (Booth, 2010).

In summary, the literature relating to young people exposed to, or bereaved by, the suicide of a peer is confounded by two streams of thought. First, that close friends are at greater risk of suicidal behaviour due possibly to their assortative relationships; and second, that close friends are at less risk for suicidal behaviour possibly because they witness how the death impacts others and this disinhibits suicidal behaviour. This confounds both who we help, and how. The current research literature is largely quantitative and, as such, the ability to discriminate between friends who are close and friends who are more distant is quite subjective. Additionally, focusing on suicide risk fails to take into account other potential problems that may manifest for young people in the aftermath of suicide. There is also a distinct lack of research involving rural young people. This leads to key questions: how do young people in rural communities deal with suicide bereavement of a friend? Has this been reported in the literature?

Prior research for the current study

Bartik and colleagues (2013a, 2013b) investigated the impact of a friend's suicide on ten young people to examine their bereavement experience. These young people were aged between 16 and 24 years when their friend died, but were aged between 18 and 29 years at interview. They had experienced 22 suicide deaths of friends, two suicide deaths of family members, plus seven other deaths of friends and family due to other causes. Nine of the young people had been resident in rural locations and five were from the same rural town. However, at interview only four young people still lived in a rural location. Five of the young people had moved away from the town where they grew up, and where their friend had died. These five young people had subsequently experienced fourteen unrelated suicide deaths and four other deaths. Leaving their rural town was a means to cope with their experience of death; this was epitomised in the opening paragraph in the introduction to this study (see Chapter 1). The narratives expressed both concern and resistance to returning home, due to their experience and their sad memories following the suicide death. Young people reported (Bartik et al., 2013b) a reduced capacity to cope with stressful situations; they were more likely to be avoidant and attempt to distract themselves and less likely to use social diversion strategies. They exhibited increased stress, depression and anxiety. Although none met the full criteria for prolonged grief disorder, they all exhibited elevated cognitive,

emotional and behavioural grief symptoms, even a number of years after the death of their friend. They described themes of: meaning-making after the death; guilt, particularly entitlement for bereavement; risky coping behaviours, predominately with alcohol and drug use; and, a reduced capacity to relate to friends with greater social isolation, particularly caution about forming new relationships due to the fear of losing close friends (Bartik et al., 2013a).

This study provided some initial insight into the suicide bereavement experience of young Australians; however, there were a number of limitations. The small sample size limited the representativeness of the results. The average age of participants (24 years) was at the end of the age spectrum (16 to 24 years) of those classified as young people in Australia (Australian Bureau of Statistics, 2010a). Perhaps due to age, most of the young people in the study were now living in major cities and had been for some time. Whether they had escaped or simply moved on, it is difficult to know whether their experience would also reflect that of younger adolescents living in rural locations. Importantly, younger adolescents would be less likely, and have less capacity, to be able to leave their rural town following a friend's suicide death. In this way, it is expected that their experience would be very different.

The lack of research with young rural people bereaved by suicide means there is little clarity about what constitutes their unique experience and, following this, what interventions are appropriate. Accordingly, there are a number of important questions relevant to this age group, including:

- What is the experience of rural adolescents who lose a close friend to suicide and continue to live in the rural location where the death occurred?
- Are there aspects of the rural location that can mollify this experience?
- Do other factors, such as stigma, exacerbate risk and result in less positive outcomes?
- What systems of support are available for adolescents and young people generally in rural locations, and do they avail themselves of these supports?
- Are suicide bereaved rural young people at greater risk of mental health issues and suicidal behaviour?
- Is there a difference in the experience of suicide bereaved young people depending on the closeness of their relationship with the friend who died?

In light of the above, the following chapter (Chapter 3) details the rationale and methods used to undertake the current study—exploring the experience of Australian rural young people who lose a friend to suicide.

Chapter 3

RESEARCH METHODOLOGY

This chapter describes the theoretical orientation, methodological approach and research design used to inform and guide this research. The purpose of the research was to understand the experience of rural young people who have lost a friend to suicide. A mixed-method design was selected with a qualitative core component as the main theoretical drive, alongside a quantitative supplementary component. The theoretical orientation selected for the study is discussed, including the justification for this mixed-methods approach. This is followed by a detailed description of the research design including the analysis process for both the qualitative and quantitative data, as well as the sample selection and data collection process. Reflexivity, rigour, methodological issues and limitations together with ethical considerations when researching sensitive subjects such as suicide bereavement are also discussed. The chapter commences by introducing myself as the researcher.

The researcher

I am a middle-aged male, born in 1959. After flirting briefly with theatre and fine arts in my early stages of academia, I concentrated on a career in the field of mental health. I commenced working in mental health and welfare in 1983 and then

gravitated to working with at risk young people. I graduated with a second degree (Psychology Honours) in 1993, with a research thesis investigating the impact of victim confrontation on juvenile offending in NSW. I moved with my family from the city to a rural location in NSW in 1994 to work in child protection. In 1997 I accepted a new challenge as the program manager for Child and Adolescent Mental Health in the local rural area health service. This newly created role entailed the building of the service from the ground up, including recruitment and development of clinical services for young people aged up to eighteen years of age. I also registered as a Psychologist in NSW.

In 1997, there was considerable funding allocated by the Commonwealth and NSW State Government to support child and adolescent mental health. One of the ground-breaking projects embraced in NSW Child and Adolescent Mental Health at that time was the National Youth Suicide Prevention Strategy, which commenced in 1995 and was completed in 1999. This strategy evolved into a broader national framework for suicide prevention (Mitchell, 2000) but was particularly influential for me in that it provided opportunities to explore a number of unique, locally based rural suicide prevention projects that further stimulated my interest in suicide prevention for young people.

I then completed a Masters qualification that enabled me to be endorsed and registered as a Clinical Psychologist. Study for this qualification included a research component, which was a pilot study in youth suicide bereavement. In this study, I collaborated with several researchers at the University of New England. This opportunity exposed me to the broader thrust of research projects in rural suicide bereavement and postvention that has encouraged and supported the current doctoral research study.

My clinical work over fifteen years has continued to focus on young people. At point of writing, I have not experienced the suicide death with any of my clients. There have been, and will continue to be, many young people I have worked with who have been suicidal, who have self-harmed, or who have been at significant risk of suicide. The distress and anguish that these young people and their family reveal constantly challenges me as a clinician but also helps to determine my resolve to work with them and support them. In the clinic, young people's stories often implicate friends as allies (and sometimes foes), so it seemed a natural progression to think about how the suicide of a young person might affect the friends around them.

Working with young people is rewarding but continually challenging. I am fortunate to be able to relate to and engage with young people, where building a strong rapport with good communication is a critical component. This skill has proved invaluable in communication with participants. However, moving from the role of clinician to that of researcher was not without its challenges. A number of the participants interviewed had significant issues occurring in their life and, while I considered that they would benefit from professional intervention, I could not offer this in the researcher role. There were also some instances where parents or carers wanted the interview itself to be therapeutic to help 'fix' the young person. Again, I needed to be very mindful and respectful of the limits of the researcher role.

The initial interviews required careful consideration of my language and responses to participants. The process of initial listening to the audio recordings of the first few interviews was critical to reveal my verbal utterances. This initial listening also prompted memories of non-verbal interactions that might normally be appropriate in a clinical interview but could impede the research interview and the flow of dialogue from the participant. This initial listening to early interviews before proceeding further was important to temper both my language and behaviour.

As a final point, I have no direct family experience of suicide. However, my own children are in the age range of those targeted in this study so my thinking and the goals of research were always tempered with: what if this was my child, how would I want their story to be heard, why is that important? It is my aim throughout the study to remain respectful of the rural participants and truthful to the goal of presenting their stories and their experience of suicide of their friend in this study.

Statement of the problem

The aim of this research was to understand the experience of rural young people who have lost a friend to suicide. The research questions are:

1. *How do rural young people live through and with the suicide death of a friend?*
2. *Are there any adverse and/or positive outcomes associated with being exposed to a friend's suicide death?*
3. *Do young people have suggestions for ways in which they need support following this event?*

Given the proposed sample size, a mixed-methods design with a core qualitative component was considered the most fruitful way of pursuing this research. The

manners in which both the qualitative and quantitative analyses were applied are described below.

Narrative analysis as the main theoretical drive

Narrative research is the study of people's stories (Polkinghorne, 2007), with narrative analysis referring to a suite of approaches used to investigate diverse kinds of texts that share a storied form (Riessman, 2004). In narrative research, clarification is sought about what these storied texts or language data are intended to represent because this form of qualitative data is not always identical to the actual experience described (Polkinghorne, 2005). The evidence gathered in this process is not used to determine whether the recalled events actually occurred, but instead is applied to the meaning attached to these events irrespective of whether the events are accurately described. In this sense, the texts are narrative truths, not historical truths. As described by Polkinghorne (2007): "[T]he storied descriptions people give about the meaning they attribute to life events is, I believe, the best evidence available to researchers about the realm of people's experience" (p. 90).

The purpose of qualitative data is to evidence the characteristics of the participant's experience. This data is a reconstruction of the past brought about by memory, which can be influenced by mood, emotional state, and suggestion. The data from

interviews is also a product of the interaction between the participant and the researcher. It is a co-construction or co-creation (Polkinghorne, 2007), with the researcher's presence an integral component of the story told by the participant. How the researcher asks questions and responds to answers has bearing on the memories recalled and, hence, the stories told by participants. The researcher also needs to go beyond the surface of what is said by participants, as narratives cannot speak for themselves (Riessman, 2004). Narratives require interpretation. The first part of this process requires selecting from all available sources those most likely to inform the researcher about the character of the experience being explored. The second part draws the data from these sources that serves to portray a rich description of the experience being studied (Polkinghorne, 2005).

For this study, narrative analysis was selected as the methodology to provide the means for deeper understanding of the unique stories and the experiences of participants. This method has the capacity to capture rich detail of the experience under consideration and so has been applied in other studies of suicide bereavement (Maple & Edwards, 2009; Maple et al., 2010). However, these studies focused on narrative inquiry as the analysis approach. Narrative inquiry configures the description of events into a story by drawing out specific plots (Creswell, Nanson, Plano Clark, & Morales, 2007). These plots are then used as the focus of

analysis to examine how participants attribute meaning to their experience. This method, described by Polkinghorne (1995), allows the researcher to collect descriptions of events that form a story with a structure of 'beginning-middle-end'. These events, tied together by plots, are attributed meaning by the researcher in terms of their contribution to the story. Used in this fashion, narrative inquiry contextualises the meaning making process by focusing on the person to give insight into how they interpret the world (Riley & Hawe, 2005).

There is no one unifying method of narrative analysis and approaches differ depending on the core questions of why and how stories are told (Riley & Hawe, 2005). In the current study, the experience of rural young people who lose a friend to suicide was lacking in the literature. The research questions included consideration of interventions and practices that might assist young people with this experience. A method was required that could identify themes across a number of participants to bring to light not only their experience but also offer insights into interventions that would best meet their needs.

Thematic analysis was selected as the method of narrative analysis for this study. This method finds common thematic elements across a number of research participants and the events they report (Riessman, 2004). Thematic analysis

involves the open coding of data—in this case, the participants' stories. This coding builds a set of themes whereby the researcher looks for patterns in the data, labels them, and then groups them accordingly. Although starting with one person's story, thematic analysis de-contextualises the data by cutting and pasting themes identified across all participants' stories to examine the meta or broader issues (Riley & Hawe, 2005). The researcher plays an active role in identifying themes and selecting those which are of interest and then reporting them (Braun & Clarke, 2006). How the researcher sees the world also has bearing on the themes identified and this is shaped by the researcher's interpretive paradigm, which is their own sets of beliefs and feelings about the world and how it should be understood and studied (Denzin & Lincoln, 2011). The researcher's interpretive paradigm combines their ontological, epistemological, and methodological premises and makes demands on the researcher that include the type of questions asked as well as the interpretations brought to them (Denzin & Lincoln, 2011).

The interpretive paradigm that structured my approach to this research was constructivist. This paradigm uses naturalistic methodology (Creswell, Shope, Plano Clark, & Green, 2006). This assumes there are multiple realities (relativist ontology) and that knowledge is generated from the mind with the knower and respondent co-creating understanding (subjectivist epistemology) (Denzin &

Lincoln, 2011). While thematic analysis can be used within different theoretical frameworks (Braun & Clarke, 2006), a constructivist interpretive paradigm matches well with thematic analysis because both hold that reality is socially constructed (Mertens, 2010). Thematic analysis as a constructionist method examines the ways in which events, realities and experiences are the effects of a range of discourses operating within society (Braun & Clarke, 2006). Similarly the constructivist paradigm holds that realities are socially and experientially based and constructed by research participants through their interactive dialogue with the researcher (Mertens & Wilson, 2012). Put more simply, access to reality is only available through the social constructions of language, consciousness and shared meanings of the participant and the researcher.

Philosophical underpinning for the research

The philosophical underpinning for the current research study was hermeneutics, which is concerned with the meaning of text and how to interpret and bring to light coherence and understanding of that text (Gadamer, 2008). The French philosopher Paul Ricoeur was a contemporary representative of hermeneutics. He focused on and elaborated issues of "lived experience, conflicting interpretations and intersubjective meaning" (Ulin, 2005, pp. 885-886). Ricoeur found inspiration in hermeneutics where the plurality of interpretations and understanding collide

(Alvesson & Sköldberg, 2009). Here, meaning was never stable and always subject to historical variability; Ricoeur referred to this as conflict of interpretations (Ricoeur, 1974). He wrote that interpretation is the work of thought, which consists of deciphering the hidden meaning in the apparent meaning, in unfolding the levels of meaning implied in the literal meaning (Ricoeur, 1974, p. xiv). Interpretation was the hinge between language and lived experience (Geanellos, 2000), and that whatever is intelligible is accessible to us only through language.

Ricoeur's (2004) writings about memory and the sense of the past identified that there is an individual's memory of what he or she did, but that there are also sets of memories shared with others. It is through these collective memories that people have access to past events that have been reconstructed and recounted to them. In this way, individual memories take shape against the backdrop of collective memories. Ricoeur's description of the building of memories, and hence historical knowledge, is analogous to the research methodology of this current study. He considered that the task of historical research is to support, correct, and sometimes refute, collective memory and that this process consisted of three elements.

The first element Ricoeur described was the building up and use of archives, which comprise documents and artefacts that record testimonies and reports about their

context. This archival work is an interpretative action that leads to the discovery of facts that most often have to do with dates, places, and names (Ricoeur, 2004). However, these facts do not relate directly to what actually occurred, but are established by the researcher's questions and are thus interpretations. This first element relates to this study's methodological process of the researcher asking questions in the interviews that aim to encourage the participant to draw out and relate stories from memory, including names and context.

The second element of historical knowledge is explanation and understanding and how historians relate facts to each other. Given action is always interaction, the researcher needs to be attentive to multiple meanings of 'why'; this is relevant to making action intelligible. The second phase of the research study was the identification of themes from the stories of participants. There were multiple meanings of 'why' in their stories, for example, closeness of relationship, influence of peers, and geographic location. It was the researcher who drew out these themes and interpreted them to best represent the participants' accounts of their experiences.

The third element of historical knowledge was the production of a verbal representation of some part of the past as a text. This is both symbolic and

interpretative, as the researcher's writings also provide material for subsequent explanation and understanding. Similarly, research findings written up for this study have become material for subsequent consideration and future research.

Ricoeur's interpretive process means the analysis of participants' interview transcripts can never entirely recreate the original event because what remains is only an impression of the language of the interview (Tan, Wilson, & Olver, 2009). The interpretation of the participant's experience is therefore dependent on the researcher and the text and, as such, rigorous qualitative research must take account of the researcher in the research process and involve honest reflexivity. Issues of reflexivity and research rigour in this study are addressed later in this chapter; however, the validation of claims about understandings of human experiences require evidence that consists of personally-reflective descriptions in ordinary language with analyses that use inductive processes to capture commonalities across individual experiences (Polkinghorne, 2007). Arguments for claims require that evidence be cited from the text in support of the claim together with why "other passages that apparently do not support the interpretation do not serve to dispute the claim" (Polkinghorne, 2007, p. 14). It is important that the researcher argues that their interpretation is viable and grounded in the assembled texts such that any particular interpretation is plausible based on the data available

(Hjelmeland & Knizek, 2010). Consistent with the underpinnings of a hermeneutic approach, it is therefore important that the interpretative findings be well grounded in, and representative of, the narratives of the participants in this study.

While participants' narratives are explored in qualitative methodology, this study used a mixed-methods design, with each participant interview yielding both qualitative and quantitative data. The justification for a mixed-methods design is discussed, followed by an outline of how the qualitative data was analysed, and then the approach to the quantitative analysis.

Mixed-methods and suicide research

The majority of mainstream research about suicide has comprised of quantitative studies (Hjelmeland & Knizek, 2010). This focus has relied on the use of deductive methodologies to seek causal explanations for the behaviour in question in a linear cause-and-effect way (Lester, 2010), which has also been described as mechanistic and reductionist (Hjelmeland & Knizek, 2010). I was conscious of the need to take a more holistic approach to examining, understanding, and reporting on participant's behaviours as they related to suicide. This understanding compels greater consideration of qualitative studies, and this is consistent with calls for suicidology

journals to encourage and publish qualitative research (Hjelmeland & Knizek, 2010).

An imbalance in suicide research methods was similarly reflected in suicide research topics. There is a need to increase research in the area of postvention to better understand the needs of people bereaved by suicide (Cerel, Padgett, Conwell, & Reed, 2009; Dyregrov, 2011). Both qualitative and controlled studies have been recommended (Andriessen, 2009), with mixed-methods research promoted as providing the nexus between explaining and understanding suicide and suicide bereavement (Hjelmeland & Knizek, 2010; Rogers & Apel, 2010).

Mixed-methods research evolved as a distinct methodology in the late 1970s (Johnson, Onwuegbuzie, & Turner, 2007). Early design consisted of the addition of a qualitative component to a quantitative study in order to make greater sense of the numerical findings (Teddlie & Tashakkori, 2011). Various definitions of mixed-methods research have been proposed and these generally refer to a combination of qualitative and quantitative research, for example "mixed-methods research … combines elements of qualitative and quantitative research approaches … for the broad purposes of breadth and depth of understanding and corroboration" (Johnson et al., 2007, p. 123). Despite the interest in mixed-methods as a topic of

research, there remains a lack of clarity, with incomplete nomenclature and little formal direction on how to undertake mixed-methods research to ensure designs are planned, rigorous, and result in strong findings (Morse & Niehaus, 2009).

The approach taken in this study uses the Morse and Niehaus (2009) definition and is guided by the exemplars where "mixed-methods design refers to the use of two (or more) research methods in a single study, when one (or more) of the methods is not complete in itself" (p. 9). Mixed-methods is thus defined as a systematic way of incorporating one or more methodological strategies into a single research study to access some part of the phenomena of interest that cannot be accessed by the use of the first method on its own. This approach makes the study "more comprehensive and complete than if a single method was used" (Morse & Niehaus, 2009, p. 9). The defining characteristic of mixed-method research is that it is driven by an inductive or deductive theoretical process and comprises a qualitative or quantitative core component with a qualitative or quantitative supplementary component.

The current study consisted of a simultaneous mixed-method design, with an inductive theoretical drive. The core component was qualitative, with a simultaneous quantitative supplementary component. Morse and Niehaus (2009) use the nomenclature QUAL + quan to describe such a simultaneous mixed-method

design (p. 25). The qualitative core component required a small, but purposefully selected, sample to provide a rich description of the experience of losing a friend to suicide. The sample selection is discussed later in this chapter. The qualitative sample is then used for quantitative measurement using standardised instruments with the scores for each participant compared with external norms and the results used to enhance the description of the qualitative sample as per Morse and Niehaus (2009, p. 67). The point of interface of the two components is the position where they meet in the conduct of the research. In this study, the point of interface is found in the discussion of the results (Chapter 7).

Qualitative data analysis

Data analysis commenced with transcription that occurred following completion of interviews. A description of the interview process follows later in this chapter. The qualitative data was examined using thematic analysis, with six phases as described by Braun and Clark (2006). The process was recursive with movement back and forth between the various phases.

Phase One: Transcription

For pragmatic reasons, the original intent was to transcribe a small number of the initial interviews myself, with the majority transcribed by a third party. However

the experience of transcribing the first two interviews resulted in a greater appreciation of the content and stimulation of thought such that all interviews were transcribed by me as soon as practicable after each interview was completed. The outcome was greater immersion in the participants' stories, plus the ability to reconcile what was said and the manner it was said and relate this to observations and comments in my interview journal. There were also a small number of audiotaped interviews that had poor sound quality due to ambient environmental noise; I would not have been confident of the accuracy of third-party transcription. Completing these transcripts shortly after the interview meant they were still fresh in my mind and, with reference to my interview journal, I was confident that the transcription was an accurate representational process (Davidson, 2009).

During transcription, I chose not to include certain oral language features expressed by the participants, such as "ums" and "errs". This meant accepting primacy of written features over oral discourse but incorporating commas, full stops, and paragraphs in the transcripts. This denaturalised approach is consistent with the view that within speech are meanings and perceptions that construct our reality and that accuracy concerns the substance of the interview shared during the conversation (Oliver, Serovich, & Mason, 2005). In this sense, and consistent with the philosophical and interpretivist paradigm outlined for this study, the transcripts

were considered theoretical constructions and the process of transcription both representational and interpretive (Davidson, 2009).

The transcriptions of the stories told by the participants were considered to be the narratives for analysis (Riley & Hawe, 2005) and part of the data set for thematic analysis (Braun & Clarke, 2006). Following transcription of the participants' stories, I listened to and re-read each interview a number of times so that I was totally familiar with each participant's story and experience. Specific parts of the narratives that stood out were highlighted and entered into a basic Microsoft Excel© spread sheet to inform the later coding process.

Phase Two: Initial codes

The second phase involved the production of initial codes from the data, with these codes identifying features of interest. Each of the participants' narratives were analysed separately with initial codes and the passages of text that represented the codes entered into a spread sheet together with the page reference for identification. These data driven codes (Braun & Clarke, 2006) were listed for each of the participants in the study, which resulted in multiple codes for each narrative and also included contradictory accounts. Text passages that represented a code or codes were expanded to capture some of the context of the narrative. An example of

an initial code and the relevant passage of narrative is shown in Table 3.1. Codes for each of the participants are listed in Appendix 1.

Data extract	Coded for
7. Not sure, I know that his grandparents are held fairly highly in the community so there was a lot of support for family, I'm not sure in what ways, whether there was sort of any financial support or anything like that but I know there was quite, it did it did shock the town because you sort of think oh, how could something like this so tragic happen in our small little town type of thing. P5.	7. Community support

Table 3.1 Example of data extract and code

Phase Three: Themes

The different codes that had been listed for each participant were compared across the entire data set of all participants to determine which codes were similar and might represent a common theme, but also might combine to form an overarching theme and/or subthemes. A theme is described as capturing something important about the data in relation to the research question and that it represents some level of patterned response (Braun & Clarke, 2006). Data relevant for each of these initial codes was combined to build up the number of extracts that represented these initial themes. At this stage of the analysis, there appeared to be some themes that were common across the data set, others that were potentially related, and others that were likely to be discarded. Considerable movement backwards and forwards between and across codes occurred at this stage as refinement of themes progressed.

Phase Four: Reviewing themes

The fourth phase involved the manual review of the initial themes, and combination of those same or similar themes under an appropriate theme name. The initial themes selected during Phase Three were pared down to sixteen themes and five subthemes from across all the participants and are shown in Figure 3.1 below. This level of analysis was aided by use of the software program QSR—NVivo Version 10 (QSR International, 2012). This program was used to code, organise and store the data for the study. Each of the participants' narratives that related to a theme or subtheme were entered into NVivo as a source item.

NODES	SOURCES	REFERENCES
- Adhoc community response to suicide	11	20
- Denying any help	2	3
- Exaggerating friendship closeness after death	9	14
- Facebook	14	50
- Friends as coping	12	22
- Gossip	12	23
- Guilt about other friends	7	14
- Impact of the suicide on friends	17	65
- Alcohol & drug use	12	22
- Suicide risk	7	12
- Importance of memorials	9	13
- Isolating from others	12	36
- Deservedness	8	8
- Life change	15	23
- Relationships	1	5
- Their decision to die	13	27
- Response to family	17	36
- School response	17	71
- Small town response	15	45
- Stigma	12	24
- Ways to help	14	33

Figure 3.1 NVivo themes and subthemes

Themes and subthemes entered in NVivo are termed 'nodes', with extracts of data relevant for each code selected and saved by the researcher. Each interview transcript is termed 'sources' in NVivo and the software counts the number of references for each theme made by participants and saved by the researcher. For example, the theme Facebook had 14 sources (located in 14 participant interviews) and 50 references (across the 14 interviews in which this was discussed). This meant I had selected and saved 50 references (data extracts) from 14 of the transcripts on this theme. Sources and references are not absolute counts from the data set however. The relevance or identification of a theme is not related to a quantifiable measure of prevalence but whether the researcher determines that the theme selected captures something important to the overall research question (Braun & Clarke, 2006). More than 14 participants in the study spoke about Facebook and the total number of references to Facebook exceeded 50. However, only 14 sources and 50 references were selected and entered in NVivo because these extracts demonstrated particular aspects of the Facebook theme that I, as the researcher, determined important. Additional references either duplicated aspects of the theme, or were determined as not significant; for example, a reference to Facebook and the promotion of a memorial event for a friend who had died.

Consistent with this phase of analysis, the collated extracts in NVivo for each theme were reviewed to ensure they appeared to form a coherent pattern. The entire data set was also reread and reviewed to determine that the themes selected worked in relation to the data set and whether there was any additional data missed from the earlier stages of coding.

Phase Five: Defining and naming themes

Given the scope of a doctoral study, not all themes can be investigated thoroughly. Therefore, this phase involved the defining and naming of the final themes to be presented in this study. The data extracts that represented these themes were reread and reviewed to determine which extracts provided the richest description of the theme identified and how many extracts might be presented to demonstrate the particular theme. Contradictory extracts were also identified and selected for inclusion. The three main themes selected for presentation in this study were:

- Communication about the death
- Community response to the death
- Coping with the death

Each theme also has sub-themes. These final themes and sub themes are presented in the thematic map below, Figure 3.2.

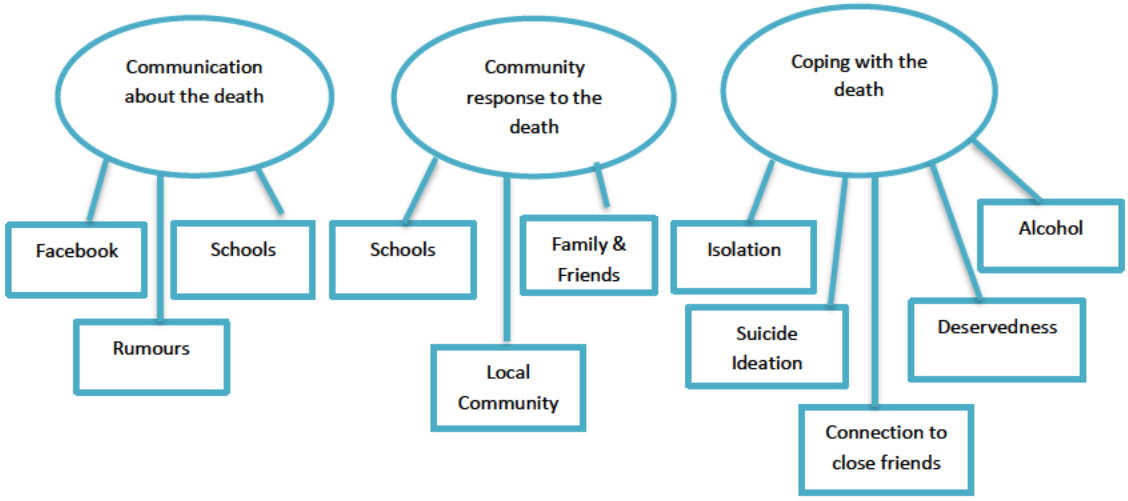

Figure 3.2 Final thematic map showing three main themes and subthemes

Phase Six: Presenting themes

The final stage of thematic analysis comprised the task of writing up the results as seen in Chapter 6. The write-up lists the final themes together with data extracts as evidence of the themes. These extracts are also embedded within a narrative to compellingly illustrate the story about the data and also to make an argument in relation to the research questions posed (Braun & Clarke, 2006).

Quantitative approach

As stated earlier in this chapter, the aim of this research was to understand the experience of rural participants who have lost a friend to suicide. The second research question asked whether there were any adverse and/or positive outcomes associated with being exposed to a friend's suicide death. Participants were

assessed for some common outcomes from exposure to suicide. These included depression, anxiety, prolonged grief, coping skills, stigma, posttraumatic growth, general health status, and alcohol use. These outcomes all relate to a continuum of experience following exposure to suicide, and have been implicated in a number of studies (Bartik et al., 2013b; Cerel et al., 2005; McMahon, Corcoran, Keeley, Perry, & Arensman, 2013; Melhem et al., 2004b).

The following quantitative measures were selected for this study based on their applicability and relevance to the age group under study and their use in other bereavement studies. A key issue was access and identification of standardised norms to enable comparisons of the sample population. Other decisions about measure selection were based on utility, such as ease of use and cost efficiency. Descriptions of the psychosocial variables under consideration, plus a description of the particular measures selected, are discussed below.

Coping Skills

The ways in which people respond to perceptions of threat, harm and loss generally receive the label 'coping' (Carver & Connor-Smith, 2010). Coping responses play an important role in physical and psychological wellbeing, with these responses partly controlled by personality and partly by the environment. They can be adaptive or

maladaptive (Carver & Connor-Smith, 2010). People who are anxious, depressed, and at risk of suicide display a significantly higher proportion of avoidance strategies in their overall coping style (Edwards & Holden, 2001). There is also the challenge of coping given the often-complex nature of the emotional relationships and attachments that may have existed between the deceased and others prior to death. This can greatly impact the intensity of grief experienced and also affect future relationships (Suicide Prevention Australia, 2009). How participants cope following the suicide death of their friend was therefore considered an important factor to determine in the context of this study.

Coping Inventory for Stressful Situations

The Coping Inventory for Stressful Situations (CISS) was used to measure coping. It is a 48-item self-report inventory that assesses task-orientated coping, emotion-orientated coping, and avoidance orientated coping (Endler & Parker, 1999). The avoidance-orientated scale has two sub-scales: distraction and social diversion. Respondents rate each item on a five-point frequency scale ranging from (1) Not at all to (5) Very much. The CISS has both adolescent and adult versions that are reported in the administration manual as appropriate for use with normal and clinical populations. The CISS is reported as having very high internal reliability with alphas ranging on the Task, Emotion, and Avoidance scales of .89, .87, and .80

respectively for female adolescents, and .91, .90, and .83, for adolescent males. Test-retest reliabilities are also reported as moderate to high. Evaluation of the CISS in other studies has found support for its psychometric properties (McWilliams, Cox, & Enns, 2003). Normative data, including means and standard deviations, are presented in the administration manual for each of the scales for adolescents and adults (Endler & Parker, 1999), and were used as comparisons with the participants.

Anxiety

Around 15% of young people in Australia have an anxiety disorder (Australian Bureau of Statistics, 2007) with trait and state anxiety shown to be predictors of suicidal thoughts (Stewart, Donaghey, Deary, & Ebmeier, 2008). Anxiety disorders in adolescence can also lead to elevated rates of anxiety and depression in young adulthood (Woodward & Fergusson, 2001)

State Trait Anxiety Inventory

The State Trait Anxiety Inventory (STAI) was used to assess anxiety. It consists of two 20-item self-report scales arranged in a fixed format (Spielberger, 1983). The state-anxiety (S-Anxiety) portion of the STAI is designed to assess the present feelings of the individual (e.g., *I feel calm*). In contrast, the trait-anxiety (T-Anxiety) portion of the STAI is designed to assess how the individual generally feels (e.g., *I*

lack self-confidence). The STAI is reported in the administration manual to have good construct validity and its reliability is high, with median coefficients of the S-Anxiety scale and T-Anxiety scale .93 and .90, respectively (Spielberger, 1983). Studies have supported the constructs of state and trait anxiety (Kantor, Endler, Heslegrave, & Kocovski, 2001). While the STAI is a popular measure used in psychological research (Gros, Antony, Simms, & McCabe, 2007), there is some consideration that the trait scale may not assess pure anxiety as it includes some items that reflect more general negative affect (Bados, Gomez-Benito, & Balaguer, 2010). However, the STAI is used because it is predictive of first–time and recurrent incidents of suicide (Goldston, Reboussin, & Daniel, 2006). The means and standard deviation, listed in the administration manual for high school students (Spielberger, 1983), were used as standardised population norms for comparison with the participants.

Depression

Depression is a major health problem in young people with 12-month prevalence rates for affective disorders (depression, dysthymia, bi-polar disorder) estimated at 8.4% and 4.3% respectively for females and males aged between 16 and 24 years (Australian Bureau of Statistics, 2007). Adolescent onset depression is particularly

malignant and increases the likelihood of recurrence and chronicity in adulthood (Cook, Peterson, & Sheldon, 2009).

Young people exposed to a peer's suicidal behaviour report greater depression symptoms (Brent, Perper, Moritz, Allman, Schweers, et al., 1993; Cerel et al., 2005), yet they are less likely to seek out professional services for their mental health problems (Australian Institute of Health and Welfare, 2011). Young people also have difficulty making known or describing their depression symptoms (Tully, Zajac, & Venning, 2009), with depression a major risk factor for suicidal behaviour (Hawton, Casanas, Haw, & Saunders, 2013).

Beck Depression Inventory 2nd edition

The Beck Depression Inventory 2nd Edition (BDI-II) was used to assess depression. It is a 21-item self-report measure that assesses the severity of depression symptoms of adults and adolescents 13 years and older (Beck, Steer, & Brown, 1996). Items are assessed on a four-point Likert scale ranging from 0 to 3 and then summed to give a total score in the range 0 – 63, with high scores indicating a greater level of depressive symptoms. BDI-II scores between 0 – 13 represent minimal depressive symptoms; 14 – 19 mild; 20 – 28 moderate; and 29 – 63 severe depressive symptoms. The BDI-II has high internal consistency at .80 and validity .93 (Beck et al., 1996)

with its psychometrics evaluated across many different studies and population groups (Arnau, Meagher, Norris, & Bramson, 2001).

Despite the widespread use of the BDI-II, there have been few validation studies with adolescent populations, particularly with non-clinical adolescent populations. A study by Osman and colleagues (2008) examined the psychometric properties of the BDI-II with a sample of high school students in the USA, and found high internal consistency and reliability comparable with adolescent inpatient and outpatient samples in the administration manual. The means and standard deviations from that study were selected as population norms for comparison with the BDI-II scores of the participants.

Prolonged grief

There is substantial evidence reported (for example, Prigerson et al., 2008; Shear et al., 2011) that symptoms of prolonged grief constitute a separate pathological form of bereavement-related distress that is associated with disability and negative health outcomes. Prolonged grief symptoms are associated with elevated rates of suicidal behaviour, functional impairments, and adverse health behaviours, together with reduced quality of life in adults, children and adolescents (Hibberd,

2013; Melhem et al., 2004a; Prigerson et al., 2009; Shear et al., 2011). However, there is limited research investigating prolonged grief with young people.

Prolonged Grief Disorder-13

The Prolonged Grief Disorder (PG-13) was used to assess prolonged grief. It is a 13-item self-report measure of prolonged grief symptoms (Prigerson & Maciejewski, 2008), that include longing and yearning for the person who died (separation distress) that must persist for at least six months after the loss (duration criteria), and be associated with feelings of confusion, trouble accepting loss, and emotional numbness (symptoms) with significant impairment in social and occupational related areas of functioning (impairment criteria). Exploratory factor analysis indicated that the PG-13 measured a single underlying construct of prolonged grief (Kristjanson, Lobb, Aoun, & Monterosso, 2006) with high internal consistency (.92-.94) and reliability estimates of .80 (Prigerson et al., 1995). However, there has been limited research using the PG-13 with young people bereaved by suicide. For this reason, means and standard deviations derived from other caregivers post-loss (H.G. Prigerson, personal communication, April 12, 2012) were used as population norms for comparison with the participants. A total cut-off score of 30 was selected based on the population means.

Posttraumatic growth

Posttraumatic growth (PTG) is considered to be positive change experienced as a result of the struggle with major loss and trauma (Cryder, Kilmer, Tedeschi, & Calhoun, 2006; Feigelman, Gorman, & Jordan, 2009). People who face major life crises typically experience distressing emotions that can include sadness and depression. These can persist for a long time with guilt, anger, and irritability being other affective responses commonly observed in people struggling with significant life problems (Tedeschi & Calhoun, 2004). However, many people who face a wide variety of difficult circumstances experience significant change in their lives that they view as highly positive (Feigelman et al., 2009; Hibberd, 2013; Tedeschi & Calhoun, 2004).

Again, there is limited research on PTG involving young people. A review of the literature by Meyerson and colleagues (2011) found 25 studies that examined posttraumatic growth in young people. Whilst a number of methodological weaknesses were identified, including few prospective studies and few with control groups, it was concluded that these studies had moved the field forward "by testing associations between PTG and conceptually-relevant variables that have found to be associated with PTG in adults and hypothesized to play similar roles in young people" (Meyerson et al., 2011, p. 957).

Posttraumatic Growth Inventory

The Posttraumatic Growth Inventory (PTGI) was used to assess posttraumatic growth. It is 21-item self-report inventory that uses a six-point Likert scale to measure the degree of positive changes that result from traumatic experiences (Tedeschi & Calhoun, 1996). Each item on the scale is rated with values ranging from 0 (*I did not experience this change as a result of my crisis*) to 5 (*I experienced this change to a very great degree as a result of my crisis*). The PTGI provides an overall scale score that can range from 0 to 105 and also comprises five factors: relating to others; new possibilities; personal strength; spiritual change; and appreciation of life. The internal consistency of the PTGI is rated at .90 and test-retest reliability at r = .71 (Tedeschi & Calhoun, 1996). While there is a developing literature base targeting young people that demonstrates the reliability and validity of the PTGI (Lau et al., 2013), most of these studies tend to use modified versions of the original PTGI (Cryder et al., 2006; Lau et al., 2013). The original study describing the development of the PTGI (Tedeschi & Calhoun, 1996) comprised participants of whom 92% were aged between 17 and 25 years with 36% having experienced bereavement. Means and standard deviations of this cohort on the total PTGI score were used as population norms for comparison with the participants. A cut-off score of 50 was selected to discriminate participants with low PTG.

Stigma

Stigma is strongly associated with suicide and mental health, particularly in rural areas. Due to the strong association between mental illness and suicide, the general public likely holds stigmatising attitudes to suicidal behaviour such that those with mental illness and suicidal behaviour are less likely to seek help (Batterham, Calear, & Christensen, 2013). Stigma also has a profound effect on people bereaved by suicide with stigma uniquely attached to suicide death (Cvinar, 2005). Those bereaved by suicide are frequently avoided by others because of cultural taboos or because of the historical stigma associated with someone close who has died by suicide (Cvinar, 2005). There is a general reluctance by those bereaved by suicide to express how they are feeling (Cvinar, 2005), and how their experience of social reactions might affect their behaviour and state of mind (Suicide Prevention Australia, 2010a). For young people, whose views of the world are shaped by experience and the influence of others, it is important to have an understanding of their views of suicide and their own stigma.

Stigma of Suicide Scale

The Stigma of Suicide Scale (SOSS) was used to assess stigma. It is a new scale developed to assess attitudes and stigma toward typical people who die by suicide (Batterham et al., 2013). The scale consists of 58 positive (and negative) one (or two)

word descriptors such as *arrogant*, *selfish*, and *an embarrassment*, that can be applied to someone who dies by suicide. The scale asks respondents to rate how much they agree with the descriptors of people who take their own lives using a five-point Likert scale from *strongly disagree* to *strongly agree.* Three factors of Stigma, Isolation/Depression, and Normalisation/Glorification are assessed by the SOSS. Strong internal consistency is reported for the three factor subscales of .95 for Stigma, .88 for Isolation/Depression, and .86 for Normalisation/Glorification (Batterham et al., 2013). The population on which the SOSS was normed consisted of people older than 18 years, with 57% aged between 18 and 24 years. Means and standard deviations were used from this population as norms for comparison with the participants.

General health

Adolescence is a critical period for the reinforcement of positive health and social behaviours as, at this stage of development, they are strong predictors of behaviours in later life (Australian Institute of Health and Welfare, 2011). Most Australian young people aged 15 to 24 years (93%) regard their general health as being good to excellent (Muir et al., 2009). However, bereavement brings with it the greater occurrence of physical health complaints, with evidence that bereaved individuals who are most in need of health care are also less likely to seek help

(Stroebe, Schut, & Stroebe, 2007). Additionally, people bereaved by suicide may not always be clinically unwell, but they are at high risk of becoming so. Adverse mental health responses typically associated with suicide bereavement, such as depression, can increase the likelihood of other health risks, including a resurgence of pre-existing health conditions, especially where there is limited social support and adverse life situations (Clarke & Currie, 2009). Suicide bereavement results in poorer physical health and increased physician visits (Latham & Prigerson, 2004). Young people may also present in general health settings, but for non-psychological reasons, when, in fact, they have mood disorders and also suicide ideation suggesting both high comorbidity and difficult detection (Joiner, Pfaff, & Acres, 2002).

Self-assessment of an individual's health is considered a simple and effective general measure of population health (Australian Institute of Health and Welfare, 2011). In the current study, participants were asked to rate their general health on a five-point Likert scale from *excellent* to *poor*. They were also asked to rate their health now compared to 12 months ago on a five-point Likert scale from *much better than one year* ago to *much worse than one year ago*.

Alcohol use

In an Australian study (Muir et al., 2009), over half of the young people aged between 15 and 17 years reported that they drank alcohol and 13% reported drinking two or three days per month. Further, 55% of males and 30% of females aged 15 to 17 years reported consuming five or more standard drinks on each occasion they drank alcohol (Muir et al., 2009). People bereaved by suicide have been found to increase their alcohol use, with some drinking to hazardous levels (Harwood, Hawton, Hope, & Jacoby, 2002). Alcohol misuse is also considered a risk and predictive factor for "poor progress in the mourning process" (Hoffman et al., 2010, p. 6); it is viewed as a temporary means of escape from the emotional pain associated with the suicide loss.

The participants were asked to rate how often they drank alcohol on a five-point Likert scale from *Never* to *4 or more times a week*. They were also asked how many alcoholic drinks they would typically consume when drinking on a five-point Likert scale of 1-2, 3-4, 5-6, 7-9, 10+. They were also asked their preferred type of alcoholic drink and drink size to assess the amount of standard drinks against NHMRC guidelines (National Health and Medical Research Council, 2009).

Participants

The aim of this research was to understand the experience of Australian rural young people who lose a friend to suicide. This required a sampling procedure that could allow for in-depth investigation of this experience. Purposeful sampling (Minichiello, Sullivan, Greenwood, & Axford, 2003) was employed because the selection criteria process allowed for information-rich cases and in-depth study (Polkinghorne, 2005). The selection criteria were: aged between 12 and 24 years; had lost a friend to suicide; and this friend had died in the rural location where the participant continued to live. No specific attempt was made to select participants based on the degree or closeness of their friendship with the person who had died. This was in recognition of the difficulty in finding suitable participants specifically for this type of suicide research that can be ethically challenging (Biddle et al., 2013; Polkinghorne, 2005).

Participant recruitment

The initial intention was to interview up to 30 participants from four rural locations in two eastern states of Australia, to offer geographic and demographic diversity. The four locations were selected because suicide deaths of young people were known to have occurred in each of the locations in recent years, and therefore other

young people were exposed to these deaths. Potential participants were informed about the study via media and community contacts, which are explained below.

Media

The University of New England issued a media release to national and regional print and radio media in each location (Appendix 2); full details of the media cover are contained in Appendix 3. In addition, the media release was also used by radio and print media in the New England area of New South Wales. The experience of the pilot study (Bartik et al., 2013a) was that media exposure in rural locations on its own was largely unsuccessful in encouraging young people to express interest in participating in the study. Media exposure did, however, result in some parents requesting further information on behalf of their children. It also prompted awareness and promoted legitimacy about the study although this also created some consternation in some locations, which is explained further in Chapter 5.

Community contacts

The experience of the pilot study demonstrated the importance of identifying key community contacts in the rural locations that I could link in with to speak with about the study and provide background information. These contacts were usually identified through networking with colleagues who were more familiar with the

rural locations and the service dynamics operating within those sites. The community contacts were generally people resident in the location and who had a role in suicide awareness, prevention, or postvention—sometimes as part of a support group and/or because they had direct experience of suicide bereavement.

These community contacts were able to advise me where best to promote the study, for example, via a Facebook suicide awareness page in one location, or a youth mental health support website in another location. Such activities led young people to subsequently make contact to enquire further about the study. In one of the rural locations, a colleague presented to an interagency meeting about suicide postvention and mentioned the study in her conclusion. A young person at this presentation had experienced the suicide death of a friend and was active in suicide awareness in the town. This individual subsequently contacted me to be involved in the study and offered to promote the study with the local networks, and on social media (see Appendix 4). In another location, a colleague supplied the name of a school counsellor. This counsellor knew of several young people at a high school who had experienced the suicide of a friend and undertook to promote the study with these students. At another site, a young business entrepreneur who was active in a local youth suicide prevention initiative was introduced to me following an interagency presentation. This person undertook to promote the study through the

local community initiative and also linked me with some key agency networks to develop further awareness.

As previously stated, the intention was to interview up to 30 young people from the four rural locations with approximately similar numbers in each location. Although the aim of the qualitative drive of the research was not to gain a representative sample of young people, it was anticipated that similar numbers of young people in each location might also allow some further analysis across and between the different rural locations. Although males are between three- and four-times more likely to die by suicide than females (Australian Bureau of Statistics, 2012), it was anticipated that the gender of study participants would be more equally divided irrespective of the gender of the friend who died.

Recruitment process

Following media exposure about the study or promotion by community contacts, either the young person or their parent/guardian made contact with me by telephone or email, and in one case via Facebook, to seek more details about the study. These people were then emailed Participant Information Forms (PIF) (Appendices 5-9), matched to whether they were a young person or a parent/guardian of a young person, and consent and assent forms (Appendices 10-

3). Contact numbers for myself, the project supervisors, and the Human Research Ethics Committee were provided on the PIF in case participants had any questions about the study. The PIF also advised participants that they were free to leave the study at any time. The circumstances under which each participant joined the study are explained further in Chapter 4.

Additionally, a small number of people contacted me (*N*=3) but were not eligible to participate because they were either outside the age criteria for the study (older than 24 years), or because the young person who died by suicide was a sibling. A number of other adults contacted me because they were interested to learn more about the study. Two of these people had lost their own child to suicide and they expressed support for the research. They indicated recognition of the impact their child's death had on others and were keen to talk about this experience. Records of these conversations were kept in my research interview journal.

In total, 36 young people from the four locations made contact or were identified as willing to participate in the study. They were provided with information packs either by myself or by the community contact. However, when I attended the respective locations to commence interviews, a number of these young people subsequently withdrew their intention to participate. Some of the young people

declined without providing a reason. Others, or their parent/guardian, provided advice that they felt the experience of suicide was still too raw and they were not keen to participate, or that they just wanted to move on and not bring up the subject again. These comments acknowledged the disenfranchised grief that often surrounds suicide death and acts as a deterrent for research participation, but also that painful memories can be evoked by research questions and this can also prevent participation (Bell et al., 2012).

The final number of participants was *N*=18. Despite the uniqueness of each site and the fact that fewer numbers were recruited to the study than had been intended, qualitative data saturation was achieved with the eighteen participants. Saturation in this sense meant that the data set was complete up to the inclusion of the final participants with only data replication or redundancy (Bowen, 2008). As described by Morse and colleagues (2002), saturation "ensures replication in categories; replication verifies, and ensures comprehension and completeness" (p. 18).

The demographic profile of the participants is presented in Table 3.2 below, leading to more in-depth profiles of the participants presented in Chapter 4.

Participant Code	Pseudonym	Gender	Age years (first suicide)	Age (at interview)	Pseudonym Friends	Gender/ Age Friend	Friend's Suicide method	Total suicides experienced. Friends: family: other deaths
B1	Adam	M	21	23	Peter/Carlos	M/14x2	Hanging/ Firearm	2:1:0 (father)
B2	Ben	M	17	19	Peter/Carlos	M/14x2	Hanging/ Firearm	2:1:0 (father)
B3	Nadia	F	14	15	Ruth	F/21	Hanging	1:0:0
B4	Amy	F	15	16	Rob/Ruth	M/15 F/21	Hangingx2	2:0:0
B5	Mick	M	16	18	Peter	M/14	Hanging	1:1:0(brother)
B6	Brad	M	16	18	Carlos	M 14	Firearm	1:0:0
B7	Sue	F	14	16	Carlos	M/14	Firearm	1:0:0
B8	Amber	F	14	16	Carlos	M/14	Firearm	1:0:2 (family-friend)
B9	Zac	M	14	14	Dan/Vanessa	M19 F19	Hangingx2	2:0:0
B10	Rachel	F	14	16	Matilda/Neil/ Bob/Chris	F14/M17 M20+ x2	Unknownx 4	4:0:0
B11	Lauren	F	14	15	Dan	M19	Hanging	1:0:0
B12	John	M	15	15	Dan	M19	Hanging	1:0:0
B13	Bronte	F	16	16	Dan	M19	Hanging	1:1:0 (cousin)
B14	Belinda	F	14	17	Michelle	F21	Jumping (train)	1:0:3 (friends)
B15	Kate	F	14	22	Louise	F/14	Hanging	1:0:0
B16	Skye	F	15	17	Ellen/Deana/ Siri.	F/15x2 F20+	Jumping hwy o/pass Asphyxia-tion/ Unknown	3:0:0
B17	Bron	F	17	20	Dirk/Jim/ Anita/Sally	M/18 M/14 F/15 F/16	Jumping (lookout)/ hanging/ unknown/ MV	4:0:0
B18	Ed	M	17	19	Mac	M/17	Hanging	1:0:0
		M7/F1	**15 Av)**	**17 (Av)**		**M19/F11**		**30:4:5**

Table 3.2 Participant Demographic Details

Data collection

All interviews were completed face-to-face. These were scheduled ahead of my visit to the site locations. In some cases a number of emails and telephone calls occurred prior to finalising dates and times. This often required careful negotiation to take into account the commitments of the participants, such as study, sports and other activities. Some participants and their parent/guardian were aware of the dates that I was attending their site but wanted to keep the actual days and times flexible till after my arrival. This induced some uncertainly from my perspective because I was attending the locations with few, or in the case of Location C, no actual interviews confirmed prior to arrival.

Interviews ranged in length from approximately one hour to three hours. This was inclusive of the time needed to complete the standardised measures, which was generally about thirty minutes. All interviews were audio recorded on a digital voice recorder. I made notes about the interviews in my journal and also entered verbatim quotes from family members or other key contacts if they were considered relevant to the research study. The participant and/or their parent/guardian determined the location of the interview based on their availability and where they felt comfortable to speak. Six interviews were conducted at participant's homes; five interviews were at participant's schools; three were at a local library; two were

in a coffee shop; one interview was in a public park; and one interview was in an office at my clinical practice.

Recruitment commenced in late September 2012 and the interviews took place between mid-November 2012 and the end of May 2013. Participants were informed prior to interview on the PIF that the study was a PhD research project and as such would take one to two years before completion. Participants were also advised that a final summary report would be emailed to them at the conclusion of the project. A small number of the participants have emailed or sent me a Facebook message enquiring as to progress of the study and reinforcing that they hoped their participation had been a valuable contribution towards the study.

Interview process

Meeting the participant and their parent/guardian for the first time usually began with some discussion about my travel to the rural location and some of the background to the study. Consent and assent forms were then completed if these had not been previously returned to me. Regardless of the prior completion of the consent and assent forms, I again asked the participant if they had no objection to audio-recording the interview and none declared any objection to this. At this stage of the interview, any parent/guardian who was present was asked to leave. I

informed them that I was happy to talk at the conclusion of the interview if they so desired. A number of participants requested a support person, of their choosing, to sit with them during the interview. I agreed to these requests as this provided another means of support for the participant should they be distressed during or after the interview.

I explained to the participant the plan for the interview. It would begin with recording some basic demographic information including their full name, date of birth, whether they were attending school or working, their age at the time of their friend's death, and the time that had passed since their friend's death. I then explained that I would ask the participant to complete the six standardised measures, plus I would ask questions about their general health and alcohol use. This would be followed by the semi-structured interview when we would talk about their friend who had died by suicide and that this interview would be recorded and transcribed by me at a later date. I made the decision for the quantitative measures to be completed prior to the qualitative interview so that responses to the measures were not unduly influenced by any emotions elicited from the interview.

After demographic information was recorded, the participant was asked to complete the six standardised measures in the order set out on the interview information sheet. This was to promote consistency between all participants. The introduction to each of the standardised measures followed the guidelines presented in each of the respective administration manuals. To ensure the participant had adequate reading skills to comprehend the questions, I asked them to read aloud the first question on the CISS (*Schedule my time better*). I then asked that they explain what they understood this to mean and what response they might circle on the test sheet. Only one participant struggled with reading. For this participant, I read aloud each of the questions on the six measures. All participants pencilled in their own answers on the response sheet.

I reminded all the participants that if they did not understand a question they should ask me for clarification. When they completed the first measure and moved on to the next, I reviewed the answers to ensure all items had been completed. Any missed responses were referred back to the participant when they finished the next measure. After completing all six measures, I asked the participant how they were feeling and whether this process had prompted any particular thoughts or emotions. Most said that they had no concerns completing the questions. I then asked the general health and alcohol use questions.

At this point I indicated to the participant that I would turn on the digital voice recorder. I again asked if they were comfortable being audio recorded and all agreed. The interview then began with the following statement:

> *I would like to start by asking some specific questions about your experience of losing your close friend (friend's name) to suicide. As we talk I may need to take some notes and remember we can stop if you need to at any time to take a break or whatever.*

This introductory statement was developed directly from the aims of this study, which were to elicit from the participant their experience following the suicide death of their friend. The semi-structured interview was organised around a set of predetermined, open-ended questions that had been developed and informed by the narrative analysis of the pilot study (Bartik et al., 2013a). These questions facilitated a more focused exploration of the participant's experience (Fossey, Harvey, McDermott, & Davidson, 2002), as listed on the interview information form (Appendix 14). Additional questions arose from the dialogue between the participant and me as recursive questioning (Minichiello, Aroni, Timewell, & Alexander, 1995). This further explored the participant's experience and also allowed them to focus on other areas of meaning that might not have been captured by the semi-structured questions alone.

At the interview's conclusion, the participants were thanked for participating and encouraged to email or message me if there was any additional information they thought might be relevant to their story. Before the digital recorder was turned off, I asked the participant how they had found the interview and whether they were feeling distressed or otherwise okay. Their responses are detailed in the next chapter, however no participant indicated any distress as a result of the interview.

Ethical considerations

An important ethical consideration in human research is the need to identify, assess, minimise, and manage any risk of harm to participants (National Health and Medical Research Council, 2007).

Ethics Approval

The University of New England Human Research Ethics Committee granted Ethics approval for the duration of the study (Approval No. HE11/178). Approval conditions required all participants and their parents, if the participant was under the age of 18 years, to be provided with an immediate crisis care plan within 24 hours of the interviews. This is consistent with good practice in suicide research (Stanley et al., 2009). The crisis plan involved listing relevant help and support services and contact details on the PIF and also promoting local services and contact

details at the conclusion of the interview. The Ethics Committee also recommended that a follow-up courtesy call be made to parents one or two weeks later. No participant reported being distressed at this follow-up, or as a consequence of the research interview.

Informed consent/assent

The consent/assent forms provided *Yes/No* options including agreement to participate in the study and to the interview being audio-recorded and transcribed.

Confidentiality

The need to maintain confidentiality is an important issue for young people and a major reason why young people develop negative attitudes towards, and are less inclined to attend, support services such as counsellors (Rickwood, Deane, & Wilson, 2007). For this reason, it was vital that confidentiality was assured and anonymity maintained with the information provided by the participants. To this end, pseudonyms were provided for all names used in the participant's stories and, to foster greater inclusion, the participants were encouraged to nominate pseudonyms. Only two participants chose to do so and I selected the remainder. The participants often enquired as to whom else I was interviewing in their location, but accepted my response about maintaining confidentiality.

Duty of care to participants

Ethical requirements can be a major issue that affects the qualitative investigation of suicide bereavement generally, and bereavement in young people particularly. It is also a possible reason why investigation in this field is limited. Suicide bereavement research is hampered by unreasonable objections raised by ethical boards (Moore et al., 2013). Ethics committees often raise the issue that participation in bereavement research by vulnerable individuals will be potentially distressing and may increase suicidal feelings (Lakeman & Fitzgerald, 2009; Moore et al., 2013). This is generally based on the view that discussing sensitive issues, such as past traumatic experiences, may intensify distress and cause harm. However, the actual understanding of participants' experiences in this type of qualitative research is limited and, as such, there may be a tendency to overstate risks and consequently shackle such research (Biddle et al., 2013).

This is likely intensified with presumed issues about young people participating in research (Powell, Fitzgerald, Taylor, & Graham, 2012). There is also a reluctance to support such research, borne out of the duty to protect participants from potential harm (Jorm, Kelly, & Morgan, 2007). With young people, the perceived risk is that discussing the bereavement experience may increase the young person's distress

via iatrogenic effects (Gould et al., 2005), and possibly exacerbate or reinforce suicidal thoughts and feelings (Lakeman & Fitzgerald, 2009).

Ethics committees have a tendency toward conservatism and paternalism (Lakeman & Fitzgerald, 2009), as well as an emphasis on the minimisation of risk (Gibson, Benson, & Brand, 2012). However, such a position potentially mirrors the wider societal reluctance to talk about suicide (Gibson et al., 2012). The fear of discussing suicide generally only serves to reinforce stigma and taboo, and fails to recognise that young people talk about suicide regardless (Fullagar et al., 2007). The minimisation of risk and harm for young people is an important ethical consideration, but this needs to be balanced with young peoples' dignity and rights of participation (Gibson et al., 2012). Concern about the potential negative impact of participation in suicide bereavement research is not consistent with reported outcomes that support the positive impact and therapeutic benefit of such participation (Biddle et al., 2013; DeCou, Skewes, Lopez, & Skanis, 2013; Maple et al., 2010; Jorm et al., 2007).

In stimulating reflection, disclosure, and catharsis, interviews can be both uncomfortable and therapeutic (Biddle et al., 2013). Interviews can represent the first, and sometimes only, opportunity to tell one's story with some people taking

part because of their own unresolved issues related to the death (Harwood et al., 2002). Regardless, participants generally report a range of benefits from the engagement, even when they have become distressed (Biddle et al., 2013). Research supports that most people appreciate the opportunity to take part and tell their story, and the importance of helping others in the same situation is an important motive for research participation (Dyregrov, 2004).

Self-care

My background as a clinical psychologist working with young people meant that I was experienced in listening and responding to stories of distress. However, the researcher role required me to put aside this clinical role and act as an impartial listener to the stories. I initially found this difficult but resisted the temptation to move back into the role of clinician. As such, I debriefed with a professional colleague who had experience in balancing researcher and clinician roles. This debriefing process helped me to better consider my responses and appreciate that I was in the privileged position of hearing participants sharing their stories. This was reinforced to me by the participant, Zac, when answering a question about what counsellors and services should offer young people bereaved by suicide when he added to his reply: " I can see where you're coming from, you really want to help and research and everything".

Reflexivity

Reflexivity is the awareness of the researcher's role and how this is influenced by the object of the study (Haynes, 2012). Reflexivity can also be used to evaluate the role of the researcher and consider bias in research design and analysis. It can be used to question and enhance understanding by acknowledging the values and preconceptions brought by the researcher to the understanding of knowledge claims (Haynes, 2012).

In this study, I held the dual roles of psychologist (internal) and researcher (external), which placed me both inside and outside the research experience. Breen (2007) discusses the insider and outsider researcher referring to where researchers position themselves in relation to their research domain. Insider researchers can be particularly confronted with certain methodological and ethical issues, such as the balance between their discipline-specific insider role (being a psychologist), and that of being a researcher. In this study I needed to be mindful of how these two roles influenced both the collection and interpretation of data from the participants. I needed to be aware of my own responses to the participant's stories by not reacting to, and engaging in, conversation as a psychologist as this might bias the nature, content, and flow of the interview.

It was important for me to remain as the researcher who helped facilitate the stories of the participants as they spoke of their relationship with the young friend who had died, and then their subsequent experience with family, friends, and their local community. While I did not actively promote my professional background to any of the participants, some did ask, either at the introduction or conclusion of the interview, about my interest and association with the subject of youth suicide. On these few occasions I was able to talk of this interest developing from my work as a psychologist with young people and recognising the morbidity and mortality associated with youth suicide. I further explained that this was an area of work and study where I hoped to make some positive change. I felt comfortable with this response and that subsequent engagement with the participants maintained the researcher relationship despite my other clinical role.

Research rigour

It is important for mixed-methods research to demonstrate and maintain appropriate rigour so that claims of knowledge derived from the research are based on the weight of evidence and the arguments offered in support of the claims (Polkinghorne, 2007). Mixed-methods research rigour can be demonstrated by reliability and validity measures (Morse et al., 2002), and also iterative mechanisms

used during the process of research (Morse et al., 2002; Onwuegbuzie & Leech, 2006; Polkinghorne, 2007).

The mixed-methods approach (QUAL + quan) allowed for multiple sources of data (Breen, 2007) with the supplementary quantitative component measures having high internal validity and reliability. A research interview journal was also maintained to document the information and data gathering process and this provided an audit trail and tool. In addition, the research method, data and findings were exposed to review from a broader academic and professional audience with a conference presentation to the International Association for Suicide Prevention (Bartik, 2013). An academic education seminar on the research was also presented at Durham University in the United Kingdom. Finally, the following chapter (Chapter 5) provides a detailed description of both the interview location and setting and the participants so that the reader can determine and consider the transferability of the findings to different contexts based on the level of similarity between settings (Breen, 2007).

Methodological issues and limitations

Overall, this study was inductive with a deductive supplementary component. The purposefully selected sample for the study reached saturation for the inductive

qualitative drive, but had insufficient statistical power (due to the sample size) and lacked randomisation to meet the requirements of deduction demanded by quantitative methods. As such, the 18 rural participants aged between 12 and 24 years could not be considered a representative sample of all young people who have lost a friend to suicide. The participants were interested and willing to talk about their experience and self-selected for the study, so the results represent the storied experience of those participants. The quantitative measures selected all relate to a continuum of experience following exposure to suicide. Participants' scores on these measures were compared to normative population scores with the results added descriptively in the results chapter. Again, these results cannot be considered as representative of all rural young people who have experienced the suicide of a friend. It is likely that these experiences may be similar to, and different from, others. However, these results fill a gap that until now has been lacking in the research literature. This study provides commencing empirical data to aid both the understanding of rural young people who lose a friend to suicide, and also suggests responses and interventions that could support young people who have this experience. Different forms of analysis of the data would likely result in additional meanings and also understanding of the experience of the suicide of a friend. The potential for different foci of research and suggestions for future research will be discussed in Chapter 8.

Summary

This chapter has focused on the theoretical orientation and mixed-method design of the study, which comprised a core qualitative inductive drive using thematic analysis and a quantitative supplementary deductive component to analyse the narratives and data completed by rural participants who had lost a friend to suicide. In the following chapter I introduce the participants who informed this research, including details of their background relationship with the friend who died, and some context of the interview and the rural locations.

Chapter 4

HIDDEN WORLDS

This chapter introduces each of the eighteen participants involved with this research study. Often young people affected by suicide are only presented as statistics. These do not portray the intensely emotional experience of losing a friend. The intent of this chapter is to present the participants by describing some of their current situations together with the relationships they had with the friend/s who have died. These descriptions are structured to also give the reader some sense of the interview environment. Each participant is introduced by their pseudonym followed by the pseudonym of their friend/s, shown in parenthesis.

A short description of each location precedes the participants who are grouped together to reflect their shared geographic location and where there is some common association and friendship to the same young person who has died. Some relate only to one friend who is unknown to others, even though the interview location and circumstances may be the same. As with any social network among young people, these relational connections are complex. Relationship maps (Figures 4.1 to 4.4) are presented for each of the four geographic locations to assist the reader in understanding the connections between participants and those deceased. These

show the connections between the young people who have died and the participant, as well as between all the participants. The strength of the different friendship relationships is depicted with coloured lines to reflect the distinct relationship groups: close friends; part of a friendship group; part of a friendship network; and siblings.

Italics are used to identify the participant's own voice. Quotation marks are used to indicate other communications derived from email, texts, and journal entries in relation to the interviews. These are all written verbatim with the original spelling and grammar. For the remainder of the thesis, each participant will be referred to by their pseudonym with a square bracket of information placed at the end of each quote that lists the particular friend/s who died, the age of the friend/s who died, and the time since the death. This allows the reader to refer back to the details contained in the summary table (Table 3.2) presented in Chapter 3.

LOCATION A

Location A comprised two regional towns on the east coast of Australia, 20 kilometres apart and 420 kilometres from a capital city. The location is known primarily as a retirement destination with links to the timber industry. With a geographic area of 3690 square kilometres, one town had a population of approximately 41,000 people, and the other town approximately 7500 people. The youth population (aged between 10 and 24 years) was 16.2% compared to the national figure of 19.7% (ABS, 2011b). The Index of Relative Socioeconomic Disadvantage (IRSD) score, derived from census variables related to income, educational attainment and employment, was 969 (Public Health Information Development Unit, 2014). The average IRSD score for Australia is 1000—scores lower than this are indicative of greater disadvantage (relatively fewer residents with high incomes, tertiary education, and skilled occupations) compared to Australia as a whole.

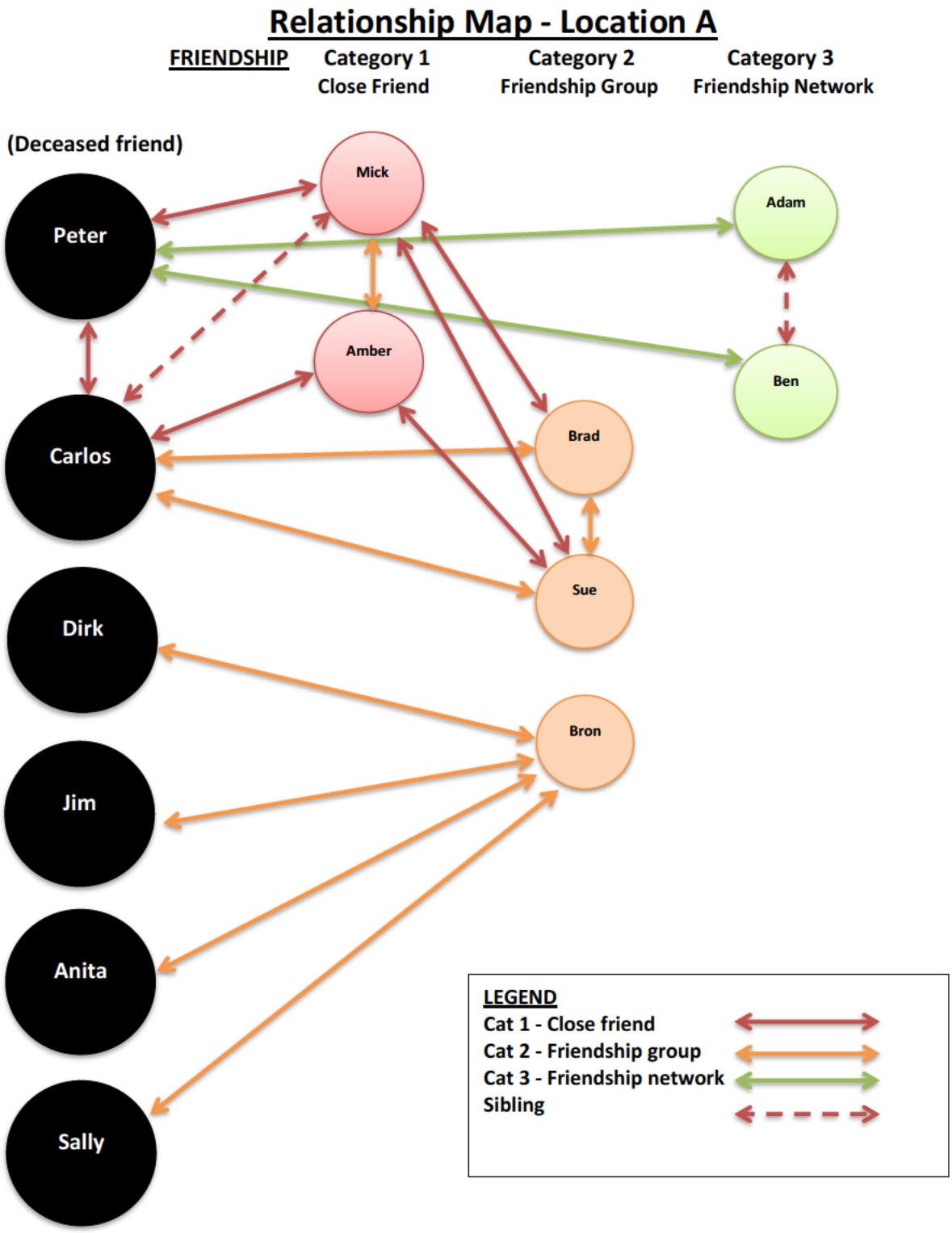

Figure 4.1. Relationship map Location A

ADAM—(Peter)

Adam was the first participant interviewed and, at twenty-three years of age, also the oldest. His mother, Joanne, had responded to a media article in the local newspaper about the study in Location A because she was aware that Adam and her younger son Ben (aged nineteen years) knew one of the young boys from their local community who had died by suicide two years previously. These two boys, Carlos and Peter, both aged fourteen and best friends, had died by suicide within three days of each other. Carlos was the first to die, followed by Peter.

Joanne had also hoped her daughter Tiffany, now aged fifteen years and who knew both the boys who died, might also participate in the research. Tiffany had not expressed any interest in the study but Joanne hoped that her brothers' participation might convince Tiffany to be involved and that she might benefit from this. Joanne subsequently emailed me to advise that Tiffany had declined to participate, telling her mother "what's happened has happened and no amount of talking about it will change it". Compounding the situation for this family was the fact that the children's father, Joanne's husband Clancy, had died by suicide six years previously. When Joanne first made email contact with me, she said that she hoped that involvement in the research would not only benefit her children but also

others. Joanne herself had commenced training with Lifeline as a volunteer, saying that it was her wish to help others and maybe prevent other families from suffering a similar painful experience to their own. She also expressed the desire to "give something back as Lifeline were a great support in the early days" after Clancy's death. It seemed that Joanne was also seeking continued solace for her own grief.

It was mid-morning on a Saturday in late spring when I arrived at Adam's home. The family still lived together in a modern home opposite a golf course in a quiet semi-rural hamlet. Its relative proximity to the coast meant the climate was warm and somewhat humid. Adam welcomed me into the home and informed me that his mother Joanne was at work for the day. Adam had lived in the same location his entire life and was now working in retail.

Adam was almost apologetic at the commencement of the interview, saying that although he knew Peter who had died, he was not a close friend. His knowledge of Peter had come about because he had been the local football coach and had coached Peter and his cousins for a number of seasons. Adam had stopped coaching because of work commitments but said he still had some ongoing contact with Peter's family and was *pretty close to that side of the family, like more his cousins* but also the parents. He spoke with some guilt because after the death he *didn't get a chance to*

talk to the boys, and I meant to and but didn't know how soon it would be and didn't know how comfortable the family would be with me talking about the suicide.

Not surprisingly, during Adam's interview he frequently compared the experience of Peter's death to that of his own father, Clancy. Adam was aged seventeen and in Year 12 at the local high school when his father died. He said he had now come to terms with his father's death: *you've got to just move on which I feel bad about sometimes, you either adjust or you don't. Like if I don't move on, get stronger for it then, then I'm just going to end up in the same way, or I could have ended up in the same way.*

Adam expressed his sadness that Peter and Carlos had died at such a young age without experiencing *any of the bursts of life.* He reconciled that his father was forty when he died but at least had *lived a little bit.* He also lamented that the boys likely felt that *they couldn't talk to anybody else about it even mention it to his* (Peter's) *family, their family must have been fairly close, he was the only boy in the family.* When Adam added that he thought Peter *seemed fairly close to his dad but he couldn't even talk to him about it* and yet his *dad always seemed to understand him, his dad didn't seem like the type who wouldn't listen to his son*, it was hard to not consider this a parallel response for Adam in relation to his own father.

Adam acknowledged that Peter's death had brought back thoughts of his own father who was *pretty big in the community, involved with football and surf clubs and stuff*. It appeared there was a pervading view that *in this town, guys shrug it off kind of thing, they kind of laugh it off, tell them to toughen up kind of thing, have a beer and stuff like that. That's half the problem I think sometimes.* Adam was expressing that this 'just toughen up' type of coping response to suicide he saw in the town was not a helpful way of dealing with the issue. However, it seemed that this was an indication of how he now felt; he was subconsciously acting this out when he spoke of Peter's cousins and family: *you don't know how much support I guess they want, like do they ever want to see anybody else. I saw them a couple of times and they seemed okay again. But behind closed doors you don't know really unless you are talking to them.*

Based on Adam's own experience, I surmised that he would have some idea of how they felt but he had learnt to cope by erecting a façade to give the appearance that he had moved on. At the conclusion of the interview Adam reiterated that he had coped well with the interview but, in general, *the coping thing for me, like just a lot easier not to think about it.*

In-text reference:

Adam: *[Peter, 15, 2yrs]*

BEN—(Peter)

Ben, aged nineteen years, is Adam's younger brother. Ben was a promising football player and had just returned home from the United Kingdom two days previously, having spent six months on a football scholarship with an English University. Ben had incurred a knee injury while away and had returned home for an operation and recuperation with his family. Ben was jet-lagged and tired when we spoke but had told his mother Joanne that he was keen to take part in the study. Throughout the interview, the family dog often wandered into the dining room where Ben and I were talking, seemingly excited to greet and be patted by someone from the family who had been absent for some time.

Ben said that his friendship and knowledge of Peter had developed because of his friendship with Peter's sister, Lyn, with whom he had gone to school. Ben said that Peter was also at the local football club; he knew Peter's mother and father quite well. Their fathers had also been friends. Peter had died when he was in Year 9; Ben had just finished Year 11.

Ben said that he was first told about Peter's suicide by his mother (Joanne). He had lost contact with Lyn when she left the school to be home-schooled, although he

understood that she had been diagnosed with bi-polar disorder. When first told the news about Peter, Ben said he was taken aback because of a misunderstanding with names. He had mistakenly thought it was Peter's father who had died and this prompted a reaction and memory of his own father's suicide death. When the information was clarified, Ben said that the news still *was quite a bit of a shock because I didn't actually know that he was friends with the other boy.* Ben explained that he had previously heard about Carlos' death the week before and with this came the realisation that the two boys were friends and that their deaths might be linked.

Ben's own personal experience of losing his father implicated him as a support for others. Ben said that the mother of one of Peter's cousins, who was *like only a year younger than me, and he was struggling a fair bit,* approached Ben's mother asking *if I wouldn't mind sort of talking, talking with him like I sort of had similar loss sort of things.* This same request was made on behalf of Peter's sister Lyn where *they sort of said if she does want to or feels she needs to talk with someone, other than like a counsellor or something, would you be happy to do it and that. And I said yeah, like I would be happy with that.* Even though he had acquiesced, Ben found this request made him *sort of nervous* because his contact with Lyn had been limited since she left school. However, *I suppose I sort of feel, pretty sorry for the family and that, so wanted to help out*

if I could. This did not eventuate because Lyn herself did not feel comfortable pursuing this type of support and Ben sounded quite relieved about this outcome.

Like Adam earlier that day, Ben also inevitably wove discussion about Peter's death with his experience of his own father's suicide. He said that others affected by Peter's suicide would likely bring this up in conversation with him because *knowing my situations, that I dealt with and the grief before, they have sort of felt more obliged to bring it up, more comfortable in front of me.* Ben confided that he was quite affected by his father's suicide and that *I sort of went through some stages where, where not to the extent of suicide but, but sort of feeling really down.* He said his experience now with Peter *brought a new perspective that there is a lot better things out there and that, and how sad it is when someone so young, like takes that option.* There was an assumption that Ben had dealt with his own grief about his father. The experience of Peter's suicide had given Ben *a better perspective on things, on how people react to such a thing, how devastating it is to not just your family but to a lot of people out there.* This realisation of the devastating impact of suicide on those left behind seemed to me more at the core of Ben's nervousness about talking to Lyn and others.

At the conclusion of the interview, Ben said that he was fine and hoped that his involvement had been helpful. He also hoped his sister Tiffany would talk to me as

she had a more intimate friendship with the boys who had died. Ben said that Tiffany had also worked with Carlos' family in their restaurant as a waitress so had more contact with the family. Ben did not seem to share the worry of his mother and brother about Tiffany describing her as *quite a strong person and doesn't let too much get to her*; he speculated whether *the loss of dad has put sort of this iron armour on her*.

When leaving the home of Ben and Adam, I indicated that I would happily return to interview Tiffany if she changed her mind and consented to being involved. After two weeks, I contacted Joanne to follow-up on both boys' response to the interview, a condition of ethics approval. Joanne confirmed that there were "no negative consequences at all and that both boys were happy to participate"; they hoped that they had been able to provide some "valuable insight into how suicide affects those left behind". Joanne added that Tiffany again had expressed no interest in being involved but wished me well for the remainder of the research.

In-text reference:

Ben: *[Peter, 15, 2yrs]*

MICK—(Peter, Carlos)

Mick became involved in the study after answering a posting to a Facebook page. A media article about the study published in the local newspaper prompted contact from a local small business entrepreneur who had taken a public stand about youth suicide by developing a youth support Facebook page for the local town and surrounding region. This person offered to post specific information about the study on the Facebook page to inform and encourage friends to find out more about the study. Mick subsequently liked the page and contacted me.

It was at this first contact over Facebook that Mick informed me he was Carlos' brother, as well as best friends with Peter. After reviewing the PIF about the study, Mick said he would also distribute this information to other friends who knew the boys and was confident that a number of friends would participate.

Later, Mick contacted me to say he had "got some people interested when u coming to the area". We arranged to meet on a Saturday to suit school and work commitments and Mick suggested the local library as an appropriate venue for the interviews. On the Friday before the interview date, Mick messaged me to say "yeah there is a couple coming but not as many as before and okay see u saturday

then". He confirmed that seven people would attend so I suggested we stagger the interviews through the day.

On the drive to Location A, and with a departure time before dawn, I contemplated the day ahead with eight people including Mick to be interviewed – I had also been able to line up two interviews for the Sunday following other responses to the newspaper article. I felt excited with the potential number of participants. At the same time, I was somewhat apprehensive because of the fullness of the day and the need to maintain concentration and focus for each participant to maximise their contribution, but also the need to be mindful of their individual well-being during, and at the conclusion of, the interview. While distracted by these thoughts, and with the early morning filtering through the forest on the sides of the road, two wallabies decided to challenge my driving skills by jumping suddenly into the path of my car. Thankfully neither the wallabies nor I came to any grief. I resolved to focus on the road and not the day ahead for the remainder of the journey. Arriving in Mick's town for a coffee ahead of the scheduled interview times, a quick check of my phone revealed messages from Mick stating the numbers had now reduced and there would only be "two of us".

The local library was very busy, most likely due to the heavy rain falling outside. As there were no private reading rooms, I set up in a quiet corner of the library. Mick arrived on time and apologised for the lack of numbers, stating that one or two of the others now had to work and that the remainder had chosen not to participate as they said "they weren't ready or felt able to do this yet".

Mick was quietly spoken, very polite, and considered with his responses. He told me he had completed Year 12 the previous year and had recently commenced an auto trade apprenticeship. Mick showed me photos of his car that had undergone a number of modifications and he laughed when telling me he and the car had become a target for the local police. He later told me he was expecting to receive notification about losing his license because of infringements incurred. Mick's apprenticeship required three-weekly attendance at a larger centre about four hours drive away, but he was unfazed saying he would rely on friends for transport. It would later become apparent that Mick was part of, and central to, a large friendship network in the town and that this group was very significant to Mick. He was also soon to become a father. Mick seemed to be a bit of a risk-taker, evidenced not least by his reports of his driving. Another participant's parent who knew Mick emailed me after I had contacted them for my interview follow-up saying they worried about Mick and, while popular, he "lives life for the moment and is a

partier". This resonated with Mick's comment to me during his interview *little things don't matter to me anymore, like I just do, what I want to do.*

I had told Mick at the commencement of the interview that the focus was not his brother Carlos, but his friendship with Peter. However, Mick told me he was first on the scene when his brother died and then three days later his best friend Peter died. The relationship between the two deaths, and their ensuing impacts, meant that trying to separate out or exclude one of these events was impossible. Mick described that he was in shock at the time and most likely he was also in denial. He told me he just wanted to *try and forget* and that *a lot of people still think I haven't dealt with it, but I don't even know myself.*

Mick's parents had retired overseas and he was now living with his grandmother. Another participant in a subsequent interview told me that Carlos had shot himself using one of his father's firearms, accessed from a gun cupboard. The parents also had a public profile in the local community as proprietors of a successful food business. It seemed to me that their motivation to leave town and their remaining son was more likely to do with their own grief and distress following this tragic event.

Mick had lost his only brother and a best friend to suicide. His parents were now living in another county, he was about to lose his license, and he was soon to become a teenage dad. Despite all this, Mick seemed quite upbeat and positive about his future. I was certain that there were two faces to this young man: the public party goer and everyone's friend who appeared to others to be bit 'out of control'; and the private, introspective young man who kept much of his inner feelings well hidden. Follow-up with Mick two weeks after the interview was that "everyone is fine and we are glad it helped".

In-text reference:

Mick: *[Peter, 15, 2yrs; Carlos, 14, 2yrs]*

BRAD—(Carlos)

Brad was one of the friends invited by Mick to come to the library to talk with me. He arrived towards the end of Mick's interview and sat quietly at a side table until we had finished. As Brad waited, I provided him with the PIF to review. When my interview with Mick wrapped up, Brad and Mick greeted each other and Brad asked whether Mick could stay for his interview. I considered this dynamic might be uncomfortable for both Mick and Brad and I raised this with them. However, Brad said that he and Mick were good mates, that he had no secrets from him, and he wanted to talk with Mick present. Mick was happy to stay for the interview and reassured he would not say anything unless asked.

Like Mick, Brad had also completed Year 12 the previous year and recently commenced an apprenticeship. Brad had grown up in Location A and had become friends with Mick in Year 9, when Mick moved to town. Brad explained that his knowledge of, and friendship with Carlos, Mick's younger brother, had come about because of his friendship with Mick. He described his relationship with Carlos as *close, but it wasn't extremely close. I knew him as one of my good mate's brothers. I was still fairly friendly with him.* Brad said that he had last seen Carlos about three days before

he died; he had found out about Carlos' suicide from a Facebook post by Mick. Brad said that he did not know Peter.

It became apparent that Brad and Mick spent a lot of time together but, whereas Mick had been categorised by some as a risk-taker, Brad gave the impression he was anything but a risk-taker. Brad appeared to be far more conservative and levelheaded than Mick and spoke very seriously and calmly throughout the interview. He said that he and his family took on a major support role for other friends following Carlos' death: *I invited Mick and his family and a lot of my friends over just to sort of get together and talk about it.* Brad's mother was also a school counsellor and it was clear that he felt comfortable and supported by his own family.

At the conclusion of the interview, Mick remarked that he was glad that he had sat in as there were instances of new information to him about his brother and the sequence of events that occurred after the death. Brad said he was also happy to have discussed his experience in front of Mick. He found that participating in this process *sort of helps you see how you have been dealing with it just by answering questions.* When I provided my interview follow-up to Mick, who had taken on board the responsibility to check in with the others he had encouraged to

participate, he replied that all was well. After emailing Brad's mother, she responded saying that Brad was fine following the interview. She also said that Brad was of course very upset when Carlos died and that since then "he has tried to stick by Mick and help set him on the right path" which confirmed the support role he spoke of during the interview. She also said that she and Brad talk about the suicide death and he is "willing to discuss things, but not for long" but "he is well aware of the huge impact that youth suicide has on everyone".

The rain had stopped as I exited the library building that was in the process of closing for the day. It was perhaps fortunate that interview numbers had reduced considerably because, unbeknownst to me, the library closed early on a Saturday and I would have been left stranded with no suitable location to accommodate another six interviewees. It was time for another coffee and to sit and reflect with my interview journal.

In-text reference:

Brad: *[Carlos, 14, 2yrs]*

SUE—(Carlos)

Sue was a friend of Mick's and one of the group he had hoped would be available for an interview; however, she had to work instead. I was driving to my overnight accommodation in the afternoon following the interviews with Mick and Brad when Mick sent me a message saying that Sue had now finished work for the day, was keen to talk with me, and wanted to arrange a time to meet. I replied back to arrange a time and suggested a local theatre foyer that I had walked past earlier that day which had a quiet corner to sit and talk.

Sue and Mick met me as arranged. Mick motioned to leave when Sue said she was quite comfortable if he stayed for the interview, and Mick agreed. A short time into the interview, staff approached to say the foyer was closing. As the rain seemed to have passed for the day, Mick suggested we move to a park in the town centre to continue the interview. This was a good suggestion but for the sporadic punctuation of a flock of cockatoos destined to take refuge in the trees and have their own conversation above us.

Sue had lived in the local town with her family all her life. She was currently in Year 11 at the local Catholic High School, the same school that Carlos had attended.

Sue said she was doing well in her studies and was hoping to continue to university study after Year 12. She also worked part-time in a retail shop after school and on Saturday mornings. Sue told me that she had known Carlos since Year 7 when they commenced school together: *I went to school with him, and he was in like almost all of my classes.* She added that they were friends and part of the same friendship group *but we weren't like real really close. There were like other people who were much closer.*

Carlos had died during the school holidays. Sue said the last time she had seen Carlos was on the last day of school before the summer Christmas school holidays *like, a month or so beforehand.* Sue also said that, while she knew Mick a little, it was not until after Carlos' death that they became a lot closer as friends. Sue did not know Peter, but they did have some friends in common. During the interview, Sue mentioned another close friend of both herself and Carlos. This friend was away when the death occurred and Sue had undertaken to break the news to them. Sue said this particular friend had continued to struggle since the death and she continued to keep in contact despite living some distance away. Sue's narrative was threaded with her role in helping and supporting others and, although she was two years younger than Mick, it seemed to me that she was also taking some responsibility to support him.

At the conclusion of Sue's interview, Mick said that there was again new information regarding the circumstances following Carlos' death that he wasn't aware of and that he found exposure to this information helpful. Sue said that she had found the interview process okay: *maybe like the length of time since when it happened it's pretty alright and I don't get upset thinking about it*. The cockatoos had taken flight, no doubt aware of the encroaching wind and rain that soon enveloped us, given our exposed location in the park.

Sue told me at the conclusion of the interview that she was happy for me to enquire via Mick with regard to the interview follow-up. Two weeks later Mick confirmed that Sue was "all good after the interview and in the time since".

In-text reference:

Sue: *[Carlos, 14, 2yrs]*

AMBER—(Carlos)

Amber was another young friend contacted earlier by Mick about the research. Subsequent to this, Amber's mother emailed me saying that Amber had received a text from Mick about the study, was a close friend of Carlos, willing to participate in the research, and had also read the media article. I sent an email response to Amber's mother providing participant and parent/guardian information about the study. Amber's mother responded shortly after saying that Amber was still keen to participate and that she had another friend who was also friends with Carlos who would attend the house for an interview. These interviews were set for the Sunday morning after the planned interviews facilitated by Mick on the Saturday. I received an email from Amber's mother on the preceding Friday advising that the other friend could no longer attend as they had work on Sunday. At that stage, I still expected to interview eight young people on the Saturday so was not perturbed that there had been a dropout from the numbers.

Amber's mother had previously advised me that their home was about fifteen minutes' drive from the centre of town but on the other side of the river. A large sporting event was being held in Location A on the weekend I had planned the interviews, and all local accommodation options had been fully booked. The closest

accommodation I could find was in a neighbouring town over 100 kilometres away. The drive to Amber's home on the Sunday morning gave me some time to reflect and consider whether Amber's interview, based on her friendship with Carlos, might differ from the previous day's interview given that Mick would not be present.

Amber's home was situated at the end of a long country laneway and cul de sac directly opposite the river. The house, on two levels with a third split level, appeared very large for a family of four (Amber's mother had stated the family composition in a previous email). Amber's mother initially greeted me just as her younger son was departing for a fishing expedition on the river. Amber then joined us and, initially, appeared somewhat shy and reticent to talk with her mother present. After signing consents, Amber's mother asked if she needed to stay with us during the interview. When I answered no, Amber visibly relaxed. I suggested that if there were any questions at the conclusion of the interview then she was welcome to join us at that time. Amber and I sat on a sunny deck overlooking the road and the river. The rain from the previous day had cleared and the mid-morning summer sun was quite intense. This had us moving frequently to keep some shade from the eaves on the house.

At the time of the interview, Amber was aged sixteen and in Year 11, at the same school that Carlos had attended. She discussed some of her interests at school and subjects such as English and Drama that she hoped would be strong in her final Year 12 exams. Amber said that she had first met Carlos in Year 7, but they did not become close friends until Year 8: *our roll call group in the mornings were next to each other and one of my best friends was in his PC* [roll call class] *so I'd go over and visit her and he'd always say 'hi, how are you going?' and he was always really friendly. Then we became like really close in year eight and like starting hanging out more and stuff.* It was not until midway through the interview that Amber revealed that she and Carlos *were actually like pretty much on the verge of going out, like becoming a couple at the time.* Amber said that this also created some confusion because, when Carlos died, some friends were not sure how to talk to her or assumed she knew certain things about the death. Amber said this was very uncomfortable for her because *everyone knew that we were sort of like that way, but we weren't actually going out. Like I wasn't actually officially his girlfriend. I felt like, a little bit awkward.*

It became clear during the interview that Amber had a large extended family who frequently stayed at the home, particularly over Christmas and school holidays; this accounted for the house size. The size and location of her house also provided a base of significant support for Amber and her friends following Carlos' death *so my*

friend Audrey came over here and then we were just talking like oh I wonder how everyone else is and stuff and we need to get together so ending up having a whole heap of my friends over at my place for the night, just all to be together. The experience of death had recently become more familiar to Amber who explained that, prior to Carlos, she had also recently lost another friend to a heart condition and then her grandfather died so she had *been through a couple of things. So yeah, we sort of knew how to deal with that.*

Amber had felt some discomfort *last night thinking about this today, I had a bit of a cry and I'm not really a person who cries* but that she had been able to talk to her father about how she was feeling. Amber said she preferred to talk to her father *cause I know mum just gets worried and I don't want to upset her.* When asked what specifically upset her mother, Amber said she still posts on Carlos' Facebook page and that sometimes when she does *mum comes and peers over my shoulder and reads what I've written because she gets all worried about me and stuff. I think she reads the stuff I post and that makes her think that there's still something wrong, but nup, I still think about him sometimes, a lot.* This potentially explained the reserve I had first seen on arrival between Amber and her mother. I also thought that the true state of Amber's feelings about her experience were probably somewhere between what Amber and her mother had expressed to me.

Two weeks later, I emailed Amber's mother for follow-up. She replied that Amber "has been fine. Hope your research goes well. There's certainly a need in this area– in the last couple of weeks there have been two girls at one of the local schools make suicide attempts".

In-text reference:

Amber: *[Carlos, 14, 2yrs]*

BRON—(Dirk, Anita, Sally, Jim)

Bron was one of the last young people interviewed for the study. While she now lived elsewhere, her home in Location A was in the same region as the preceding participants when she experienced the suicide of her friend so her story is included here.

Bron was a twenty year-old first-year university student at the time of the interview and living at a university residence. At a dinner function with fellow students and academics, Bron mentioned that she had experienced a friend's suicide death. Academics who were aware of my research suggested she contact me about participation in the study. After initial email contact and the provision of participant information, there was a delay before Bron recontacted me. She advised that she had returned back to her home town in Location A for the mid-semester break and apologised that she would no longer be available for the study. I replied by email that I was more than happy to travel to speak with her or could wait until after the holiday break and reassured her that participation was voluntary and confidential. Receiving no response, I anticipated that Bron had developed 'cold feet' about the study: by now I was accustomed to young people withdrawing after expressing initial interest. I decided it was not appropriate to push Bron by sending

another email. Encouragingly, about four weeks later Bron made contact explaining that she had been sick but still wanted to proceed. We arranged to meet in a local library.

On the afternoon of our meeting the only available space at the library was a small corner nook that allowed us some privacy. Bron explained that she had grown up in Location A and her family continued to reside there. We began our discussion about Dirk who had died by suicide about three years previously.

From the age of thirteen, Bron was a self-taught figure skater so would regularly attend the ice-rink at a local tourist attraction. She had first met Dirk about twelve months before he died. He lived in another rural town about 100 kilometres away and was an ice-hockey player, so he attended the same ice-rink on Friday and Saturday nights. Bron explained that, while she would not describe him as a close friend, *all the regular skaters would just hang out together. And that was kind of how we met.* When asked to recall the last time she had seen Dirk before he died, her eyes filled with tears. She had been speaking to him on a Friday and he had been discussing relationship problems with his girlfriend. He died on the following Thursday.

Bron described the shock she experienced when he died, particularly when she found out later that *he had threatened his girlfriend with suicide if, cause she was going to leave him.* Bron said this was doubly distressing for her because *my boyfriend told me* (about the death) *and then of course he broke up with me the week after that.* Bron also revealed that she had previously experienced three other friends who had died by suicide who she knew through school or through other school friends. First, Jim, who was in Year 8, had died when Bron was in Year 7. When Bron was in Year 10, Anita died. Sally suicided the following year. Bron said Jim's death was particularly hard, not just because of her age and being the first death of a school friend; she *had just gone through something huge, cause I was sexually assaulted when I was younger, so when the first time it happened my depression and anxiety got worse.*

Bron continued to be teary throughout the interview and her voice often broke as she talked about her friends. Bron's mother had been receiving treatment for depression, so she was no stranger to being around people who might experience mental health issues. However, Bron was positive about the things in her life to date. She had continued to skate and had done well in her Year 12 studies and now, her university studies. Bron also identified a strong support network. During the interview, I frequently checked in with her about how she was feeling. At the conclusion of the interview, Bron replied that it had been hard and that she did

have some anxiety leading up to the interview but that she felt okay and it was important to contribute to the research. At the two-week follow-up, Bron reiterated that the interview was initially difficult but she had suffered "no ill-effects" and again expressed her interest and contribution to research in this area.

In-text reference:

Bron: *[Dirk, 18, 2yrs; Jim, 14, 7yrs; Anita, 15, 3yrs; Sally, 16, 4yrs]*

LOCATION B

Location B was an inland town in north-western Australia, located approximately 900 kilometres from the nearest major city. The location was known primarily for its mining operations, and had a geographic area of 43,310 square kilometres. The population was approximately 21,000 people, with a youth population (aged between 10 and 24 years) of 24% compared to the national figure of 19.7% (ABS, 2011b). The IRSD score was 995 (Public Health Information Development Unit, 2014).

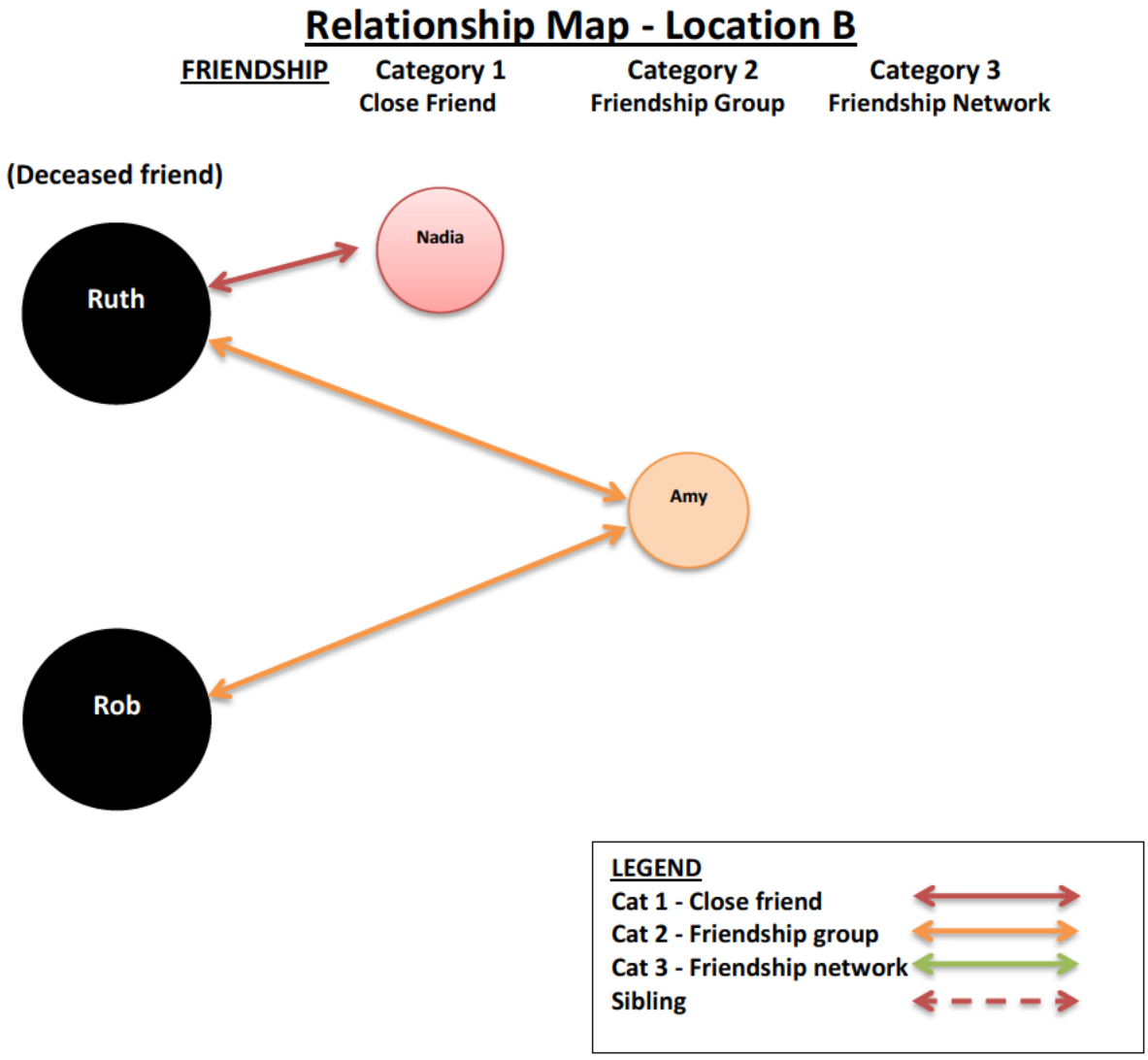

Figure 4.2 Relationship map Location B

NADIA—(Ruth)

Nadia and her family lived in a central inland town at Location B. The interview with Nadia was the first of approximately eight interviews that were planned to occur over a week for this particular rural location. The trip to Nadia's town comprised a six-hour drive followed by a three-hour plane journey. The day-time temperature forecast for the week was 40 degrees Celsius.

Nadia's mother had heard about the research study from information posted on a Facebook site (see next participant story—Amy). After talking it over with Nadia, her mother contacted me by email to obtain more information. She was keen for Nadia to be involved; Nadia was "looking forward to participating in this research and having an input". Arrangements were made to interview Nadia at her home in the afternoon following school.

The temperature had reached 40 degrees at 3pm when I arrived at the door of Nadia's home. Nadia, her father, and two silky-terrier dogs greeted me. I was grateful that the home was air-conditioned and for the offer of a chilled glass of water as Nadia and I settled into the interview perched across a kitchen bench top.

The dogs stationed themselves under Nadia's feet, perhaps keeping guard, but most likely to escape the outside heat.

Nadia was fifteen years old and a Year 10 student at the local high school at the time of the interview. She lived at home with her parents and one brother. Another older brother lived at a separate address in town. Nadia was quite shy at the commencement of the interview and remained quietly spoken for the entire interview. She responded to preliminary questions with only a few words and a mainly flat affect. For most of the interview, Nadia rarely looked me in the eye except for when we spoke about her dogs and sport, which were her two prime interests. The audio-recorded interview with Nadia was the shortest of all the participants.

Ruth had died by suicide nearly twelve months ago, when she was 21 years old. She had been the defacto partner of Nadia's older brother–and Nadia's friend. Nadia first met Ruth about seven years ago when her brother started dating her in Year 10. Since that time, Nadia said she was constantly in contact with Ruth *texting and stuff, talking over the phone and they would visit us and then we got quite close, pretty much like sisters.* Nadia explained that her brother and Ruth had broken up but were getting back together and that she continued to remain close to Ruth despite the

relationship difficulties with her brother. At the time she was active in sport but had few close friends and, as such, had developed a close relationship with Ruth.

Nadia said that on the day Ruth died, she woke up to her parents rushing out of the house to the property that her brother and Ruth rented from her parents. Nadia's parents returned two hours later *and pulled me out of my room and told me that she* [Ruth] *took her own life.* Nadia's brother was not living with Ruth at that time, so the family was focused on finding her brother to tell him what had occurred. For Nadia, this focus on others was a pervading theme as to how she viewed Ruth's death and the impact on her.

Nadia said it took three hours to locate her brother and tell him what had occurred. In the ensuing days, police and counsellors attended their home but when I asked what supports were in place for her, Nadia replied *no, there was no-one for me.* Nadia added that what she wanted was *just someone to give me the time of day, to be there, to give me a hug, that sort of thing.* Nadia acknowledged that feeling left out by her family in the aftermath following Ruth's death was *sort of my fault, I didn't like people being around me when I lose someone. Only particular people around me, and usually that's not family.* Halfway through the interview, Nadia's mother arrived home from

work. After briefly greeting me, and with minimal engagement with Nadia, her mother excused herself and left us to continue the interview.

Nadia then further elaborated on the role that Ruth played in her life. There was emotion in her voice when she said *she was a big sister, she was always here, she was the only one who put in the time and effort, like family do obviously, but she wasn't blood family but she still was there.* Nadia explained that since Ruth's death, she had become a Christian and joined a youth fellowship group, although this did not appear to be about seeking or finding spirituality to deal with her grief. Nadia was somewhat dismissive about the church saying *they talk about how people who commit suicide go to hell and they usually lie to people.* Involvement with the church group had, however, helped Nadia make a new friend, Marion, who now appeared to occupy the role that Ruth had played in Nadia's life: *she pretty much is like a sister to me now, she pretty much helped me with that like the Christian thing.*

Nadia said that, with the impending 12-month anniversary of Ruth's death, she had spoken to Marion and was confident that, with her support, she would be okay. Nadia was also hopeful there would be some support offered from her family. When asked about the interview itself, Nadia replied that it was okay *cause I know that doing this, it all is going to help others.* Nadia's mother re-joined us at the end of

the interview and our conversation turned to the two dogs. Nadia visibly brightened when talking about this subject and displayed increased interaction with her mother. I left the family home after about an hour. The temperature outside had not dropped.

Follow-up with Nadia's mother two weeks after the interview confirmed that Nadia *is doing really well* and had exhibited no distress following the interview. However, I did wonder, given Nadia's view of her family's lack of support and awareness of her distress following Ruth's suicide, just how much Nadia was letting on to her mother about how she was really feeling.

In-text reference:

Nadia: *[Ruth, 21, 1yr]*

AMY—(Rob, Ruth)

Amy was a 16-year-old high school student who heard about the study following a community network meeting held at Location B. A suicide postvention colleague had spoken at this meeting to discuss suicide response services and had mentioned the current study on my behalf. Location B had a high media profile as a rural community with a number of suicides over the last three years. Amy contacted me by email and expressed interest in participating saying she had been "effected by the loss of several young people in my community". She wanted to "assist in any possible way as I have started a youth organisation assisting young people in coping with the loss of their friends/neighbours and family".

Following the provision of information about the study, Amy confirmed her interest in participating as long as the interview did not interfere with her Year 12 studies. She added that her friendship group comprised "approximately six people who have been effected by suicide and they may also be interested". In a follow-up email, Amy stated that she had made a status post about the study on the youth suicide initiative she had established on social networking site, Facebook. She had "contacted a few people but I can guarantee you at least 6 or 7 people to have a chat to" and that the local youth organisation might also provide a venue for interviews

and a possible source of additional participants. I was buoyed by these conversations and the suggestion that another six to eight participants might be available for interview when I arrived. This would capitalise on my time and softened the travel time and expense that would be incurred, as well as the anticipated heat, travelling to Location B.

Prior to travelling to Location B, a press release was issued about the study and this appeared in the local newspaper. The aim of the press release was to stimulate interest and promote credibility about the study to both young people and their parents who had been contacted by Amy but had not yet directly contacted me for background information. While waiting in the airport transit lounge ahead of my flight to Location B, I received phone calls from two senior managers from local government services, as well as a journalist from the local newspaper. These calls were in response to the press release.

The managers and journalist wanted to talk to me about the study and my presence in Location B, but they expressed very different views about my imminent visit. The service managers wanted to "alert me to difficult local politics, concern about suicide and that my presence might agitate the issue and that local services might struggle to cope". There was a further suggestion that I should have "discussed my

intention to undertake interviews with key players ahead of any media about the study and prior to coming to Location B".

An alternate view was expressed by the journalist who spoke of a "local policy of not reporting suicide". The journalist was aware of the Mindframe (Commonwealth of Australia, 2011b) national media initiative concerning the reporting of suicide but stated the pervading local issue was "a sense of isolation in the town and a fear that talking about suicide is going to make the problem worse so it is better to leave it hidden". The journalist also stated that this view was perpetuated by local agencies that were "very good at meetings but not work or results". The journalist added that the town had "few general practitioners, none of whom bulk-billed and this made it very difficult for young people to access help". The journalist also said that the newspaper supported Amy and her attempts to drive some change for young people in the town and that my presence as an external researcher was welcomed as it might "bring some accountability to insular local services".

Sensing that my presence had the potential to stir up issues in an already complex environment, I thought it might be prudent to meet the service managers as soon as possible the next morning and to also provide a follow-up interview with the local media.

At our meeting, the service managers repeated their concern that "the research might agitate and foster a rush of young people to already stretched services" and they were surprised that the research had been planned without discussion with their particular service agency. I explained my presence and the low-key nature of the study and that interview recruitment had occurred via contact with a local young person. I also spoke about the interviews held thus far and the pilot study that had not raised issues for participants who instead felt empowered and positive about their experiences. I also reinforced that it was unlikely that the interviews would impact on local services. The managers then raised the fact that service agencies in the town had become divided about plans to tender for a new youth mental health service. The managers did not know Amy or her Facebook youth support page but expressed concern about links with the local youth organisation saying that this organisation was at odds with the "mainstream services" in pushing to be the lead agency applying for a 'headspace'[1] service to be based in town. The main issue raised was finite specialist staff already working in Location B "and that no other services had the staff resources to also service a headspace centre". While more services were needed, the "headspace model would not solve this". At the conclusion of our meeting, and having had the opportunity to check

[1] headspace (headspace, 2014) is funded by the Australian Government Department of Health and Ageing under the Youth Mental Health Initiative Program to provide mental help and support for young people aged 12 to 25 years.

my credentials and rationale for the study, one of the managers stated that they now "felt more comfortable about the research". However, the other manager remained concerned about the "impact on already overwhelmed staff".

After leaving the service agency, I pondered the number of complex issues raised in the meeting, irrespective of any impact the study may or may not have on the young people in Location B. Of primary concern to me was the issue of 'gatekeeping' that had been advanced by the service agencies that were fearful of a flood of referrals being prompted by the research study. Such gatekeeping has major potential to not only impact services and hinder support for people bereaved by suicide, but also support for those deemed to be part of the service's core business. The issue of gatekeeping is discussed in more detail in Chapter 6. I was also aware that any media about the research needed to be sensitively handled so as to not inflame already tense and suspicious services. I also made a note to ensure contact with local services ahead of my future visits to other locations for research interviews. Finally, I was concerned that Amy, who appeared to demonstrate passion and interest supporting local young people, might become collateral damage in the local service politics. I suspected I would be walking on eggshells for the remainder of the week in Location B. When I climbed into my rental car at

10.30am, the external temperature gauge measured 35 degrees climbing to a forecast of 40 degrees. It was going to be a long hot week!

That afternoon I met separately with both the manager of the local youth organisation and the journalist I had spoken to on the phone when at the airport. Both were supportive of the research and undertook to promote the study where possible. They also confirmed their support for the enthusiasm and work undertaken by Amy to support her peers. The youth organisation manager was critical of mainstream services in town that were "failing to meet the needs of local young people by remaining elitist and purely clinically focused and not engaging with young people at risk".

A representative of the local lesbian, gay, bisexual, transgender (LGBT) association also called me. The representative was interested in suicide issues relevant to the rural LGBT populations and wanted my response to some of these issues as a question and answer forum to be posted on their Facebook site along with information publicising the study. Despite the negative introduction of that morning, the level of interest expressed by others buoyed my thoughts of collecting rich research data from a number of participants in Location B.

I had previously arranged with Amy that we would conduct our interview in the afternoon of my last day in Location B. Anxious to shore up other participants, I emailed Amy who responded with "unfortunately I had 3 of my own group say they can't or don't want to participate". However, she was still hopeful that another three young people would be available and agree to participate in the study. As the week progressed, however, these three young people declined to be involved in the study. I contacted the local youth organisation but was informed that none of their clients had expressed an interest in participating.

I gave an interview on local radio about the study and again spoke with the journalist who agreed to publish a follow-up story to drive local interest and stimulate potential participants. The journalist confided that they were aware of negative responses about the research and the desire to hide the issue of suicide in the town; this was likely discouraging young people from participating. As evidence of this negative response, the journalist advised me that the material that I provided to the LGBT association, which had been posted to their Facebook page with information about the study, had "shut down" communication on the page and that "pressure had been brought to bear", resulting in the information's removal.

I had been in Location B for five days and completed one research interview. On the second last day, Amy emailed me confirming she was still available for our interview but was apologetic that no other young people had come forward or wanted to proceed with an interview. It was apparent to me that, while gatekeeping had actively thwarted my research in Location B, this issue was symptomatic of a much broader concern about suicide and stigma in this rural community.

My interview with Amy occurred on the afternoon of the last day of what had been a long and frustrating week. As if on cue, the oppressive heat throughout the week had built up into local storms and heavy rain had begun to fall. At Amy's request we met after school in the town's only café, which, at 3pm, was quite crowded. The rain outside and the crowd inside created a background cacophony that I knew would impede the clarity and audio quality of the interview recording but there was little choice other than to proceed.

Amy and her family had relocated from a coastal farming property to Location B about eleven years ago. She first met Rob at the start of Year 1: *I'd just moved here for school so he was one of the first people I met.* Amy said that her friendship with Rob developed as part of a group of mutual friends but that they were not best friends. The last contact she had with Rob was at school at the end of Year 8; after that, he

became heavily involved with alcohol and drugs. Rob remained at school but he rarely mixed with Amy and the same circle of friends, although they had some social networking contact via Facebook.

Amy said that news of Rob's death was delivered by a friend who posted Rob's name and 'rest in peace' on Facebook. Amy said at the time *I read that thinking what, what do you mean*? The following day at school, all Year 10 students were informed that a student had died but no other details were provided: *they didn't tell us any circumstances or anything, they didn't give us a name, they didn't tell us whether they were male or female. They said the police have told us there has been a death and anyone who feels they may be affected can speak to a counsellor, and that was the only news that I heard.* Amy said that rumours began to circulate that it might be Rob or someone else in their group. That afternoon a mutual friend who was close to Rob called Amy and confirmed that he had died by suicide.

Amy said she had difficulty accepting the news: *I thought they were kidding, like at that age everyone's always joking around, cause I hadn't heard about it happening and it just didn't occur to me that it could be true. I thought okay it's a joke and it took I think three or four days to sink in.* Amy said that the thought that young people might be thinking about suicide was completely foreign to her: *it didn't even occur to me that*

people that young would have that thought so *it was a bit of a wake-up call and a shock really to hear that people our age were thinking about that and doing that.* Whilst counselling was offered at both high schools in the town, these sessions were limited in time and availability so Amy, and many of her friends, chose not to attend. Amy became concerned about a number of her friends who started using alcohol and drugs to cope with their grief: *one of my friends in particular, she turned to alcohol and drugs, as a main thing to do. So every weekend it was, she would go out partying or she'd do drugs and try and, I think she was just trying to get away from the pain and the memories pretty much, because she had been really close to Rob.* About three weeks after Rob's death, another friend rang Amy *at two o'clock in the morning and said I am standing in my bedroom with a rope and I don't know why.* Amy and her sister were able to phone the friend's parents that night to intervene.

These experiences had a major impact on Amy who thought: *we can't handle this, we're going to lose all of them. We had grown up with these people, to go through year one, year eight, you know people too well to watch them throw their lives away.* Amy said that about six months after Rob's death, and having seen many of her friends struggle, *I basically said to one of my other friends I don't think this is a good thing, we need to do something.* After a number of ideas were canvassed, Amy and her friends decided on a Facebook page that could provide information about resources and activities to

support young people. A graffiti art competition was held to raise awareness and discussion about youth suicide in the town. Amy said she undertook a number of radio and newspaper interviews but also received *some pretty negative responses, like I had professionals saying to me you don't know what you're talking about; you don't understand the psychology behind it.* Amy said she was phoned by a health professional based on the coast who questioned why a group of teenagers would be involved with such an activity: *he contacted me as, and singled me out I think from my group and said you are fifteen, what do you know about life, you have no experience. I can remember I said to him, I think I might have an idea, just a little bit of an idea. I'd lost, at that stage I'd lost two friends to suicide and if I have this experience now, in ten years' time, how much will I have gained if this continues. He had no response, I think he pretty much hung up the phone after that, he made an excuse and that was it.*

Amy said her second friend, Ruth, had died by suicide twelve months ago; Ruth was 21 years old when she died. Amy's great-aunt had fostered Ruth's mother and Ruth and her brother had been family friends for some time. Amy recalled that when her family moved to Location B they often visited Ruth and her family who lived a little out of town. In turn, they often assisted Amy's family *taking care of us kids if mum and dad needed to go do things at the bank or that kind of thing*. Amy and Ruth had been most in contact when Ruth was aged about sixteen or seventeen

years but this had lessened, although Amy's parents and Ruth's mother were in regular contact. Amy had maintained contact with Ruth via Facebook and had just spoken to her in the few days before her death *and she seemed perfectly happy, no real problems*.

Amy recalled the day she found out about Ruth's death: *my mum was on Facebook and her* [Ruth's] *mum had posted a image with a rest in peace underneath it, and it was still like again, are you being serious, is this really happening and after Rob I sort of, it only took me a few goes to understand it actually had happened.* Amy said that, while the news did not shock her to the same degree as Rob, there was still *disbelief it was still, but I know that person, they wouldn't do it.* Ruth's mother was very distressed and, because she did not live in the same town, continued to ask Amy and her family questions about Ruth's death, trying to *come to terms with it which makes it harder when she tries to talk to us. A lot of it is she brings it up in a way that we can't really answer. Like she questions us what we did and it makes us think like how did we know that was going to happen*.

Amy said that both Rob and Ruth's suicide death had involved alcohol and other drugs and that this was in response to family and relationship issues *they wanted to go down the path of being able to block out the pain.* However, Amy did not accept this

as a reasonable consequence and told *one friend who went down the path of blocking it out, if you are going to do that, don't talk to me, I can't handle that*. Amy said this made her determined to support other options–hence, the Facebook page.

Amy was also more positive about mental health and stigma in the town. She said that, prior to the suicides, access to mental health services was more restricted *if you were in that risk category you got in straight away but if you were maybe on the verge of that category you didn't hear about it.* Now services were *in the mainstream, the mental health help is there* with mental health promotion posters and flyers at school as well as networks and workshops on offer. Amy said this more open attitude had impacted positively on young people in town who were now more aware that they might be stressed and at risk: *my friends keep an eye on everyone else and I keep an eye on my friends to make sure that they aren't falling or follow where they should be, or if they need help I can try and help them or find someone who can.*

The rain had become heavier and Amy was grateful for the offer of a lift home that saved her mother venturing out in the weather. After dropping Amy off at her home, I reflected on the passion with which she had spoken about her desire to help young people in the town. While I still remained concerned about local service politics, it seemed to me that Amy was largely oblivious to this but, in any case, was

strong enough to be able to continue her role with the youth support page despite the brewing standoff between agencies.

That afternoon I rang the local service manager who confirmed that media about my visit and the research had not resulted in any additional referrals. Follow-up with Amy about two weeks later also confirmed that "yep I'm all good. At the moment I'm currently undertaking exams, so everything is as normal as it gets :)". I 'friended' Amy's page and it continues to post support resources and positive mental health messages to its friends.

In-text reference:

Amy: *[Rob 15, 22mths; Ruth, 21, 1yr]*

LOCATION C

Location C was a coastal town in north-eastern Australia, and located approximately 300 kilometres from the nearest major city. The location relies heavily on tourism, and had a geographic area of 2,356 square kilometres. The population was approximately 48,260 people, with a youth population (aged between 10 and 24 years) of 23.5% compared to the national figure of 19.7% (ABS, 2011b). The IRSD score was 898 (Public Health Information Development Unit, 2014).

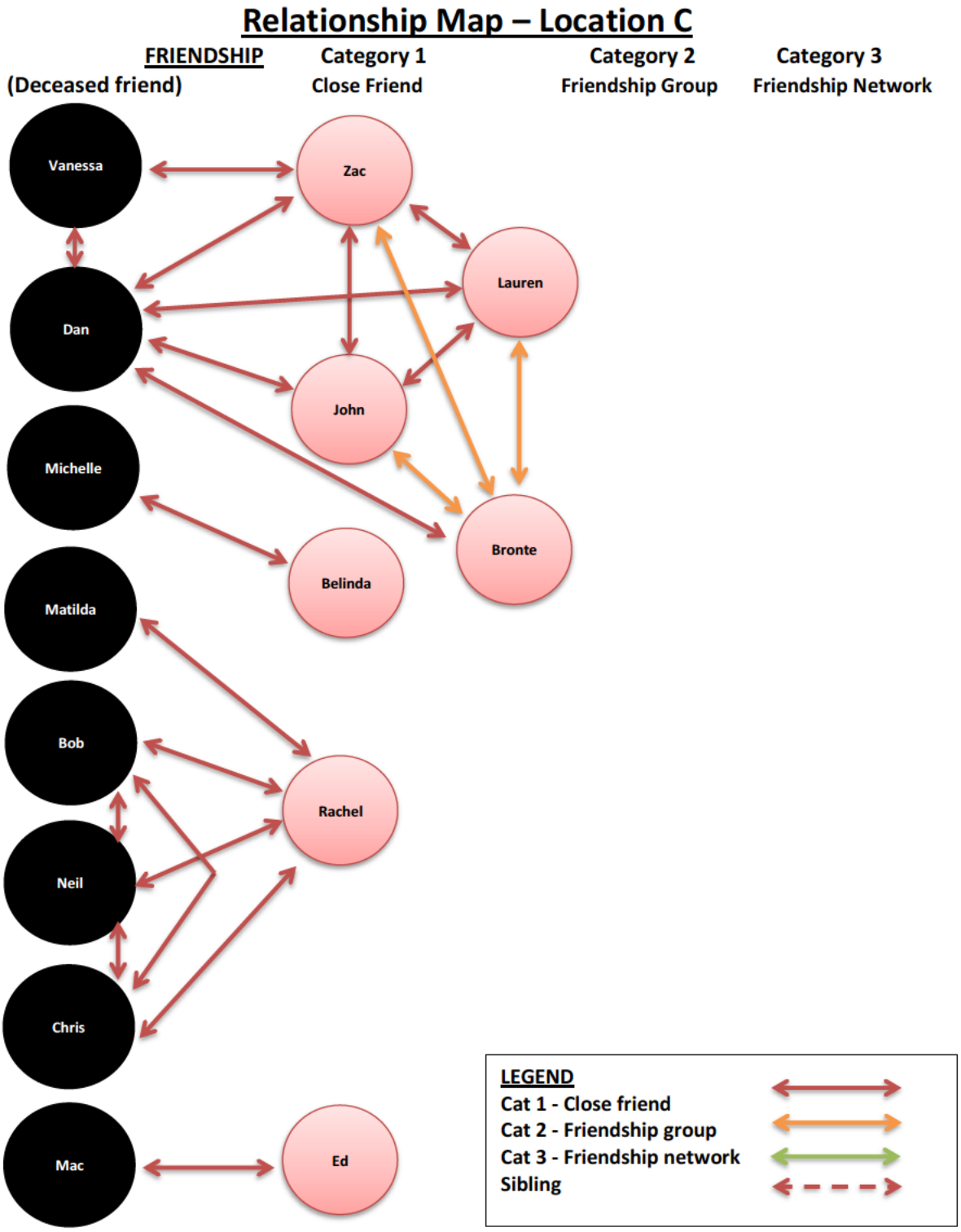

Figure 4.3 Relationship map Location C

ZAC—(Dan, Vanessa)

Location C was a regional coastal town about ten hours drive away. My prior experience in Location B prompted me to contact key services in Location C ahead of any media releases and well before my arrival to conduct interviews. Information was sent to a number of service agencies, the local youth centre, school counsellors, and a suicide support group. I telephoned the manager of a key mental health agency to talk about the research and proposed interviews and highlighted the issue of concern about impact on referrals. The manager welcomed the research saying "it is appropriate that young people be referred if needed". I felt comfortable that gatekeeping would not prevent young people's participation in the research at Location C. A media release prompted a local newspaper story and I spoke with two school counsellors. Despite encouraging initial responses, my travel to Location C occurred without any research interviews having been pre-arranged.

Heavy rain had started to fall on the east coast of Australia in the days ahead of my drive and there was local flooding at a number of localities on my planned journey. On the day of travel, the rain was forecast to ease and road reports indicated that my route was clear of flooding. I set out still enthusiastic that preliminary prompting of services and media would result in requests to participate when I

arrived. The rain did not ease during the journey; in fact it became heavier as I approached the halfway point. Flooding had closed a number of roads resulting in significant detours. The remainder of the journey consisted of three flooded river crossings aided by local emergency services. I arrived in Location C some thirteen hours after my original departure time.

On my first morning, I met with a local Aboriginal Elder and a counsellor who told me that a young Aboriginal girl had died by suicide just over a week ago. The local community was still grieving following the death. This meant it was unlikely that any Aboriginal young person might want to be interviewed, even about previous suicide deaths of friends.

I contacted school counsellors at three of the local schools. One school counsellor replied that their principal had refused to promote the study or allow participation of any school students. I was later informed that this school had experienced the suicide death of three students over the previous twelve months. The school counsellor at another school was more positive and agreed to discuss with other teaching staff and provide information to students who could then contact me. However, despite follow-up with the school, no students made contact. The third counsellor was from an independent school for young people who were at risk of

exclusion from the education system generally, due to behavioural issues. This counsellor spoke to me about youth suicides that had occurred over the last six months and assured me that a number of young people at the school had been offered information to participate in the study. Some had declined saying, "they don't want to do it or talk to anyone". The counsellor said she would again promote the study at school and recontact me.

My initial enthusiasm had started to wane. It appeared that gatekeeping now from the schools, as well as current grieving in the local Aboriginal community, might prevent young people from participating. That afternoon a grandmother who had read about the research in the paper called me. She said she was very worried about her grandson, Zac, who was currently in her care and had recently lost two close friends to suicide. Zac attended the independent school and I arranged to meet Zac at his grandmother's house the next afternoon. The next morning, the independent school counsellor rang me saying she was aware of Zac's request and also had another seven or eight young people who had expressed interest in the study. With information going home to parents and guardians that day, it was anticipated they might be available for interview over the next two days.

Zac's father, Tom, greeted me on the front verandah when I arrived at the address. He handed me the consent papers saying he was very keen for Zac to participate as he thought the process might be therapeutic for his son. Zac's parents had been separated for some time and Zac had been living with his mother, but a recent breakdown in their relationship had resulted in Zac moving to his grandmother's house on a temporary basis. Tom worked in the mining industry and was usually away on ten-day shifts but wanted to establish more permanent arrangements for his son's care. Through a window I observed an elderly couple seated inside the home who I presumed were Zac's grandparents. They often looked out towards me but did not come outside to speak. Zac emerged from the house and asked to sit on the front veranda for the interview, telling me he did not want others in the house overhearing our conversation.

Zac was aged fourteen but looked older. He said Dan had died last year, having just turned nineteen. Zac said he had known Dan since Zac was in Grade 5 when they met at the local skate bowl and had become good friends. Over the two years they had become particularly close *and I hung out with him all last year, every single day.* Zac added that they had a large group of friends. Zac said he was initially friends with Dan's younger brother but then he *just started hanging out* with Dan. He said they would ride their bikes together and do *anything that would just give us a buzz,*

energy or excitement. This included lots of parties and drinking: *the amount of times me and him got drunk as together.* Dan had dropped out of school in Year 10 and Zac was currently in Year 10, having changed schools a couple of times due to behaviour problems.

Zac said that he was one of the last people to talk with Dan before he died. He said Dan had posted a status on his Facebook page: *it's my time to go, I'm so full of the people I hurt, love all my family.* Zac immediately rang Dan, and, after a brief phone conversation, Dan repeated, *it's my time to go*. Zac said he responded: *please Dan, don't do it, I love you bro, he said I love you too and hung up on me*. He then waited for his sister to return home to drive him to Dan's house. He ran to the front of the house and heard Dan's girlfriend, Megan, crying out loudly. Going in through the front door, he saw Dan lying on the floor with rope around his neck and Megan giving him mouth-to-mouth resuscitation. Zac checked Dan's pulse, which was very weak *and then we had four ambulance and eight cop cars rock up*. Dan was then taken by ambulance to hospital. Zac spent the first night at hospital with Megan and saw his friend only briefly *then I never saw him again.* Dan did not regain consciousness and died three days later.

Zac said that Dan had previously talked to him about suicide saying: *I feel so bad I want to kill myself*. This had come about due to problems in Dan's relationship with his girlfriend, Megan. Dan would then dismiss the comments saying, *yeah, I probably wouldn't do it anyway*. However, Zac was not convinced *cause he was so ballsy, he was always the one doing stupid stuff, he had no fear whatsoever.* Zac added that, to everyone else, *Dan was the most happiest person in the world. The happiest person, that's why no-one gets it.*

Zac took Dan's death very hard. He said that he and his friends drank alcohol to cope: *I drunk twelve days straight after that*. When asked about his family, Zac said his father was shocked by the death but was away working at the time. Zac's antagonism towards his mother was evident when he said that, prior to Dan's death, he had talked to her about Dan discussing suicide *and she said don't worry he'll be fine, he won't do it, most people that say they'll do it, won't do it. And the day I found out he passed away, I called my mum and I said I fucking hate you.*

Zac's second friend to die by suicide was Vanessa who was best friends with his sister's ex-boyfriend's sister Vivienne. Zac and Vanessa had become quite close friends *and I used to like chill with Vanessa all the time and Vivienne so then we got to know each other more.* Vanessa had died only two weeks before my interview with

Zac and he was still clearly distressed. Zac said Vanessa had hung herself and that he had spoken with her about three days before she died. Zac was not sure about the circumstances of her death saying only: *I have a feeling her drink was spiked*. Similar to Dan, Zac also described Vanessa as *the most beautiful, happiest girl ever.*

It seemed to me that Zac bore a considerable burden beyond grieving his friends and this likely related to his more intimate knowledge about the circumstances of both Dan's and Vanessa's deaths. He also was concerned about the impact on other friends within his group saying: *it's only going to happen again. I know another one's coming, I seen, I'll see more of it in my life I know I will, I'll see probably more than that.* Zac told me he was keen to support the research: *I can see where you're coming from, you really want to help and research and everything* and was hopeful that this might assist others. He also acknowledged that he had a good relationship with Joss, the school counsellor, and would talk to her if he felt upset or distressed.

When the interview was over, Zac confirmed that talking about the deaths had been okay. He then excused himself and Tom came outside thanking me for my time and repeated that he thought it was important for Zac to be able to sit and talk. Tom had made an appointment for Zac to see a psychologist and I replied that I thought this was a good plan.

Two weeks later I sent an email to Joss, the school counsellor, to enquire how Zac had been since the interview. Joss replied that Zac "is not doing too well. He is now also booked into a local Psychologist for further counselling. There are a few contributing factors and I don't feel it is primarily due to his friend's death. He is receiving a lot of support from school and family". This response did not surprise me, although I felt assured that the interview had not added to Zac's grief.

In-text reference:

Zac: *[Dan 19, 3 mths; Vanessa 19, 2 wks]*

LAUREN—(Dan)

Lauren was a student at the independent school and expressed her interest in participating in the study to Joss, the school counsellor. Lauren was one of eight students Joss had scheduled to meet with me at the school over two days.

A bright sunny morning greeted my arrival at the school. The flexible school curriculum meant that students could arrive early for breakfast, were freed from wearing a uniform and the school day commenced at 9am and finished at 1pm. My presence at the school raised no particular attention, likely due to a range of external professionals who attended the school to support students. Joss greeted me and, after introductions to the principal and other teaching staff, settled me into an activity room and supplied me with a schedule of the young people to be interviewed. Two young people scheduled to talk with me had already declined. One of these was Lauren's younger brother.

Lauren was a quietly-spoken girl aged fifteen years, then in Year 9. She had grown up in the local area but did not want to discuss her own past in any detail. She lived with her mother, two brothers and stepfather. An older brother lived in town. Lauren had known Dan since she was eight years of age. They were really close

friends *and almost dated once, but we didn't want to ruin our relationship, so we had like a pretty good relationship, like a nine out of ten relationship.* She had seen Dan about four weeks before he died. They *had chilled and stuff and walked around the town.* Lauren described Dan as a really happy person who enjoyed life and she *never really thought that he was one of the people that would do that.*

Lauren first heard of Dan's death through a Facebook post, although at that time she did not believe the post, saying that friends and others would often *make jokes about it* [suicide] *and say what would you do if I passed away, you know sort of like a joke.* A friend then phoned her and, again, she thought the friend was joking, but they replied: *no I'm being serious and it was really like a shock cause I thought that he would never do it.* The friend told Lauren that Dan had hung himself. After ending the phone call, Lauren spoke with her younger brother who also knew Dan and then her boyfriend and she wrote a note *to kind of help deal with it.* Following the initial distress about the news, Lauren felt supported by her family and friends but she had been seeing the school counsellor and a private counsellor for issues that occurred prior to the death. She described other friends who were very stressed, with alcohol a common coping mechanism. Lauren described a close friend of Dan's who was not coping with the death and was drinking heavily. She described helping: *I'm supporting that friend as best I can.* She was also attempting to support

her other friends: *I always tell them that I am there for them if they need me. If they need someone they can come with me to my counsellor.*

Lauren spoke of the rumours that spread once news of the death began to circulate. She said these rumours consisted of where Dan died, that he was very depressed, but in general the *many rumours were pretty ridiculous.* Lauren said that she discussed the rumours with one of her close friends and they determined that the rumours were being made up by people who *didn't like him.* Lauren was able to dismiss the rumours by talking with Dan's family.

Dan's death had a major impact on Lauren: *it's made me realise how important my life is, just made me think twice before I'd say if I'd let people go, this has made me think what's going on at home first.* She was upset by other people's comments on Facebook following the death — some people were *really mean* about Dan, saying that *he was like a deadshit anyway.* Further: *it was upsetting to read those types of things because it just showed how selfish some people can actually be, and not realise that this person had issues and couldn't take it anymore so he took his life. A lot of people don't understand.*

At the close of the interview, Lauren felt positive about talking about Dan's death: *yeah, it's been pretty good, cause I've, I am a lot better than I was before.* At the two-week

follow-up, Joss advised that Lauren had coped well with the interview and there were no ill effects.

In-text reference:

Lauren: *[Dan 19, 3 mths]*

JOHN—(Dan)

John was fifteen years of age and lived with his father. He was of short stature and mostly quietly spoken, with his head lowered beneath a baseball cap. Prior to the commencement of the interview, John asked whether the audio recorder could be turned off if there were things he did not want recorded. Without asking what these things might be, I reassured John that all names and locations would be de-identified and only I would listen to the recording but, of course, if there was anything he did not want to be recorded then he just had to tell me. John was very thoughtful about the questions asked and there were often long pauses before he answered. He made no request to stop the recorder during the interview.

John had moved to Location C about three years previously. He had commenced at the independent school this year after being suspended, and then expelled, from the two other high schools in town over the previous two years. John said when he first came to town he became good friends with Dan's brother. He was frequently at the brother's house and would often go out with the family and, because of this, also became close friends with Dan. John was in contact with Dan through Facebook the day before he died. Dan was telling him that *a lot of people were giving him shit and I was saying, who are they and I'll deal with it, and he's just like no it's all good, they'll all*

get their day. John said this referred to other people saying that Dan and his girlfriend were 'cheating' on each other, but he understood Dan's meaning to be that he would manage these people: *he didn't want me to do anything about it, he'd do it himself.*

John said he first heard the news of Dan's death from a Facebook 'RIP' status posted by someone he did not know very well. John said he commented on the post but was thinking: *like he's not dead, this is fucked, this is a stupid joke if it's a joke.* John then contacted Dan's brother who confirmed the news and he immediately went to see the brother and *was chilling with him for a while. Just talking to him about it and remembering stuff.* John found out more information from other friends and later from the family at the funeral about what had happened.

John commented that he considered Dan to be someone who was *always happy and cheerful and I was really so surprised when it happened.* He said that in the days after Dan's death, a significant amount of alcohol was consumed as a way to cope, but also to commemorate his friend. John said he was *drinking a fair bit, me, my mate and his brother* and that Dan *was a real big drinker and he would always go out partying and we were just doing it in memory of him.*

John became slightly agitated while discussing another student who had recently come to the school and had been implicated in the relationship issues between Dan and his girlfriend. John admitted: *I know some of the truth, of the thing that happened with the girlfriend,* which was *just making me want to flog him, belt him at school.* John had refrained from causing any trouble because he did not want to be expelled, as *I'm here on my last chance so if I get in trouble then I'm out.* He also said: *I can't do that to Dad,* and explained that prior to his birth, he had an older brother who had drowned in the family property's dam.

John identified a close connection with his father, who was someone he could talk to if upset but, in general, John preferred his own counsel and would rather not bring others into his problems: *I will just keep it to myself.* I suspected that, while John tried to contain such issues, they must inevitably break out, probably in the form of violence, and this was likely behind his previous school expulsions.

At the conclusion of our interview John said of his participation: *it doesn't make you feel great, like it brings it all back in your head, so it's hard to think of what to say, but apart from that it's all right.* At the two-week follow-up, Joss advised that John had been okay following the interview. However, I did wonder how long John might be able to keep his behaviour in check for some of the other reasons outlined.

In-text reference:

John: *[Dan 19, 3 mths]*

BRONTE—(Dan)

Bronte was sixteen years old and had been a student at the independent school for the last two years. Joss, the school counsellor, said that, after initially expressing interest in the study, Bronte had developed cold feet. She did, however, agree to the interview if her close friend, Anna, sat in with her. I was happy to agree to this request. Bronte was very quiet and reserved and, throughout the interview, she would regularly turn to Anna for guidance or to seek confidence to answer questions.

Bronte had seen Dan *round town heaps before* but only became good friends with him over the last year when they met through a good friend of Dan's girlfriend. Bronte said she saw Dan the day before he died when they *were chilling for a bit* at the local shopping centre: *we were actually smoking, and just mucking around, having fun.* Bronte heard the news of Dan's death through Facebook and her first reaction was disbelief. It was only because Dan's girlfriend and Dan's mother were also writing things on Facebook that she accepted the news was real. Bronte said that she had no idea he might take his own life: *nup, nothing at all. All his family loved him, all his friends, we didn't have no idea why this happened, it just happened.*

After Dan's death, Bronte wanted to know what had happened but did not hear much. She said that she and Anna had spoken with some friends but she was fearful about the impact this might have on others: *we didn't really talk to anyone cause we weren't sure, we didn't want to upset anyone anymore so we thought we would respect them by not talking.* Bronte's only option was *reading the Facebook page, reading anything we could about it.* For Bronte, acquiring information was also hindered because of her shyness and reluctance to engage with others socially: *we* [Bronte and Anna] *really don't mix we keep to ourselves.* Bronte was aware that Dan *used to drink a lot* and that *he had a fight with his girlfriend,* which had contributed to his decision to take his life.

Bronte had also lost a cousin to suicide in the last two days. He was aged about thirty and lived in a larger city. Bronte explained that she did not see him that often and was not that close to him, so the impact of his suicide was different to her experience with Dan's death. In this case she was concerned about the broader impact on the family as she was aware of another cousin *who was closer, I am scared that he is going to do it now. He's twenty nine. The family's scared, he's tried to do it before and the two of them are really close.* Bronte said she was more *in shock than anything else at the moment because I can't believe he actually did it.*

Bronte was visibly upset about her cousin and said that *family support* was important in helping her manage this situation. However, overall, Bronte's main source of support would continue to be her friend Anna, as she did not like talking to counsellors. She acknowledged that talking about the suicide deaths had been difficult as things were still a bit raw for her: *yeah it is but I'm fine with it.*

Follow-up with Joss, the school counsellor, two weeks later confirmed that Bronte was doing okay and had expressed no issues following the interview. However, I did consider that Bronte's reticence to share her issues with others likely meant that Joss would not actually know the true state of how Bronte was feeling or what might have been happening for her family.

In-text reference:

Bronte: *[Dan 19, 3 mths]*

RACHEL—(Matilda, Neil, Bob, Chris)

Rachel lived with her mother and had been a student at the independent school for about twelve months. Rachel was of Aboriginal descent, sixteen years old, and had lost four friends to suicide. She had been bereaved by the death of Matilda, her closet friend, first.

Rachel said that she and Matilda were the same age and had first met at school in Grade 2 in another small rural location where Rachel's father still lived. Rachel said they were the best of friends and lived about a block away from each other. She described Matilda, *like my sister, she practically lived with me and we did everything together.* At school, they were part of a broader friendship circle but would *break off into little groups and it was always just me and Matilda.* Rachel smiled as she recalled telling me about their games as kids *jumping from the jetty and swimming* and the plans they had made to travel the world when they were older.

Rachel was fourteen years old and in Year 8, when Matilda died. She had been with Matilda during the day, and on the night she died: *it was about two hours before.* Rachel explained that she thought Matilda *always was never happy* and that *you could always tell there was something playing in the back of her mind.* Matilda did not have a

good family life, which was why she spent so much of her time at Rachel's house. On that particular night, *she got a call off her mum and told to go home. She ended up heading back home and that was the last time I heard from her.* Rachel knew Matilda used to self-harm *but I never thought she would take it to the point that she did.* She added that Matilda's dad had died by suicide about six months previously *and I think that's what influenced her.* Rachel thought Matilda *was definitely depressed* and that she *had really bad anxiety too after her dad passed away.*

Rachel lived opposite the local police station and, at about 9pm on the night Matilda died, there was a lot of activity: *we lived in a very small town so anything that happened was kind of a big deal.* Rachel walked outside her home with her mother and saw a police car stop at Matilda's house. She thought *maybe something had gone up there about her dad or something along the lines.* The next day, Matilda did not come to school and at about 10 o'clock in the morning the school principal spoke to the school saying: *Matilda's not coming back to school, she's passed away.* When Rachel got home from school that afternoon, her mother was talking to Matilda's mother who was crying. She told Rachel what had happened. Rachel said this news was the worst thing she had ever experienced: *hearing that they have killed themselves, taken their own life is worse than hearing that they have passed away.*

Rachel did not cope well with Matilda's death: *all I did was lie in bed and cry all the time.* She began to withdraw from other people and ended up moving away from the town after three months, *just cause I couldn't handle being in that town any more. However,* moving to another town did not alleviate the distress of her friend's suicide death and she refused to attend school for about four months. When she did attend, Rachel said she was incredibly distracted and unable to concentrate: *I just sat and stared blankly into space and that's how it was for about seven months.*

In addition, Rachel admitted new friendships made after Matilda's suicide had been problematic. These new friends were *actually a lot older than me* and *when I started talking to other people again I got really bad with alcohol and a lot of drugs.* Two of the male friends in this group, Bob and Chris, died by suicide in a short space of time, which had significantly impacted on Rachel: *oh fuck, I can't, this cannot be real, this cannot be happening, like its three people.* When her fourth friend, Neil, died by suicide just over twelve months ago, it *was just the icing on the cake.* Rachel and Neil were very close for a period of time and they had dated before Neil returned to his pregnant ex-girlfriend.

Rachel said the cumulative impact of these experiences of suicide resulted in alcohol and drugs becoming a way of coping, *because you don't, you don't think about*

anything... certain drugs make you want to get up and go out and have fun so you're not sitting there, you're not thinking, it's not playing on your mind all the time. However, things spiralled out of control for Rachel: *it sent me insane, I just could not handle it, I went to juvey.* When released, and after the suicides of her friends, Rachel moved with her mother to Location C and this had been significant in her rehabilitation as *it made me wake up to myself,* it took a long time *but once I got up here* she *got clean and sober.* Rachel also reflected on her friends and how close they were, *like brothers and sisters* and that now she could see *they wouldn't have wanted drugs in their life the same way.*

Rachel still goes back to the original small town to visit her father. She also sees Matilda's younger sister who lives there and talks to her about the things she and Matilda did together as friends. While being there *tears you apart,* it also helps Rachel connect and feel closer to Matilda. When she walks to Matilda's house, *there's that little feeling I always get when I was younger, that I was going to see me best friend.*

Rachel admitted that talking about her friends, particularly Matilda, was difficult but *it's easier now than what it was.* While she had been scared she might break down, *it's something you just push to the back of your head when you talk about it.* At the

same time, Rachel was positive about the study saying: *I think it is fantastic what you are doing, I hope this does make a difference*. At the two-week follow-up Joss, the school counsellor, confirmed that Rachel had experienced no ill effects from the interview.

In-text reference:

Rachel: *[Matilda, 14, 2 yrs; Neil, 17, 1 yr; Bob 20+, 1yr; Chris 20+, 1yr]*

BELINDA—(Michelle)

Interviews had been planned with two students on the second day at the independent school. Upon my arrival Joss, the school counsellor, informed me that one of the students who initially expressed interest had subsequently declined to participate. My final interview at this school was with Belinda, aged seventeen.

Belinda was living with her grandmother and had come to Location C and the school to *start fresh.* She explained this was because she had experienced the suicide death of her friend Michelle, and then the deaths of four other close friends, over a period of twelve months. Three of these friends had died by misadventure and one from natural causes. Belinda said that, after these deaths, and their ensuing grief, *I was really messed up completely, I just didn't care about nothing, and got expelled three times from different schools.* At the time of the interview, Michelle had died three years previously, aged twenty-one; Belinda was fourteen years old at the time. Belinda had known Michelle since she was four years old and described Michelle as her *bigger sister*. They were close friends whose two families would often spend time shopping, going to the city, and spending time together. At the time of her death, Michelle also had a four-year-old son.

Belinda's grandmother was the first person to tell her of Michelle's death, on the same day, just after Belinda had come home from school. Belinda responded in disbelief, then shock, when her grandmother told her: *she committed suicide, she jumped in front of a train, and she done it in front of her son and mum.* Belinda *couldn't deal with it, couldn't talk or nothing.* She had seen Michelle about two weeks before she died and *she was just happy, laughing, smiling, full of laughter.* Belinda was helping pack moving boxes and then they spent some time in the garden with Michelle having *a couple of drinks* and *playing with her son in front of the pool.*

In the days following Michelle's death, Belinda found seeing Michelle's mother and son particularly distressing. She felt unable to return to school *for about a month and a half* and experienced difficultly sleeping: *I couldn't, I can't sleep by myself, I couldn't sleep by myself.* Further, Michelle's son's *about three, or four nearly five, and he's the spitting image of her. I can't even look at him.* Michelle's family were from New Zealand, and Belinda attended the funeral there but it was not a good experience: *it was my first big experience of death*. Subsequently, these negative feelings had been compounded by attending the funerals for three of the other friends who had died, *like I've been to three funerals since that, I can't even stand the thought of it anymore.*

It took a long time for Belinda to be able to talk to anyone about Michelle's death: *I didn't want to let go, I didn't want to accept that she might have gone.* Talking to Michelle's mother helped her overcome some of her grief, *seeing as it was her daughter and she could talk about it, I just thought well I can talk about it as well.* She also considered that Michelle had likely suffered from depression and alcohol use had influenced her decision to take her own life: *I actually think it was, probably was because of her drinking, heaps.*

Despite some resolve about Michelle's death, the impact of her other friends' deaths had continued to weigh on Belinda. The greatest impact was her best friend, who had died three years previously and, more recently, her sister's boyfriend, who had choked to death in bed: *I still don't want to accept the fact that he's dead and my brother-in-law I can't, won't accept that either*. Belinda's experience of not talking about her grief had been unhelpful: *I wish I had spoken to someone at the time.* She was, however, appreciative of the fresh start at the new school and that she could now open up to friends and the school counsellor.

Belinda said that being able to talk about her experiences in the interview had been okay: *yeah like it's good, I can talk about it now, but back then there is no way I could have*

done this at all. Follow-up with Joss after two weeks confirmed that Belinda had not expressed any issues about her interview and there were no concerns.

In-text reference:

Belinda: *[Michelle 21, 3 yrs]*

ED—(Mac)

Ed was nineteen years old and the last participant interviewed for the study. His mother had seen the media material about the study and made contact over email. Ed then confirmed his willingness to be involved in the study but requested his girlfriend sit in on the interview.

Ed was currently in Year 12 at a local high school and lived with his parents and younger sister. His friend Mac had died by suicide about two years previously. While they knew each other in junior school, Mac had moved away. When Mac returned to school in Year 8, they then became close friends. However, Mac lived a considerable drive away so he rarely saw him outside of school. They did spend much of their school time together: *we just hung out at lunch, in the breaks, most of my classes were with him and we got along.*

Ed had seen Mac on the day that he died and nothing seemed untoward: *we were just talking casually and normally.* After school, Ed attended swimming training with a friend and was later told that Mac had tried to call the friend a number of times. However, because she was also in the pool, the calls were missed: *he didn't leave any messages, didn't actually say anything, and then we didn't hear from him again.* The

following day at school, Ed saw the teachers come out of a meeting and some were crying *so we had an idea something had happened.* Ed's year grade were then assembled in the chapel and told that *late yesterday evening, Mac hung himself in his bedroom.*

Ed was uncertain about why Mac took his own life: *we don't know why or anything like that.* He did say that Mac smoked marijuana on a regular basis and this was another *one of the reasons I didn't stay or go round at his house.* Ed was later told that, on the night Mac died, he had an argument with his mother and when she checked on him an hour or so later he was dead. Ed also explained that Mac was not popular at school and was bullied by his peers. Ed was also bullied and that is why they got along so well: *yeah he was probably as popular as me, which wasn't very popular.*

The news of Mac's death shocked Ed but, unlike many of his other friends or classmates where *ninety percent of them were crying, or cried later on,* Ed did not show any overt distress: *yeah, I never really showed, any grief over it.* Ed has *always wondered why I didn't end up, didn't show anything from it* but could offer no explanation. Despite this, Ed began to withdraw from others: *I just kind of like distanced myself from the situation and talking to people.* This became a way of coping as Ed became frustrated at the way others talked about Mac's death and its impact. Others had

apparently sought to identify someone or something to blame for the death: *it just annoyed me the fact that they could instantly blame someone for what happened.*

As a consequence of Mac's death: *I appreciate every day more…obviously appreciate things better. Relationships, I have been appreciating them more, having people there*. Ed reflected on a horse camp that he and Mac had attended a few weeks before Mac died. The instructor who led the camp was used to working with *those kind of kids, the ones that don't really want to be at school, very close to dropping out kind of thing which is what he was;* this instructor had spent a lot of time talking to Mac. When the instructor was told what had happened, *she was distressed, I think she went to the funeral.* This impressed Ed who now saw it was important to *talk about things in our lives that have gone on where we don't just hide it down, hide it from each other.* This was even more salient when Ed identified his own issues: *well I have been in that situation, with the whole depression and even attempted suicide.* He considered that the manner in which Mac died had likely influenced his own behaviour *possibly, with me trying to hang myself like he did. I suppose with his, with what happened to him kind of gave, brought up the idea that I could, do it the same way I suppose.*

Ed had continued to face a number of issues, including difficulties with his family relationships and his own mental health. He had continued to see a psychologist to

assist with depression and thoughts about suicide and self-harm. Over the last few months, he had made good progress with school and had commenced part-time work; a good relationship with his girlfriend and her family offered him considerable stability. I considered that Ed had most likely wanted his girlfriend to attend the interview as a support person but also to allow her to gain some greater insight into his past circumstances and the impact on him.

Ed confirmed that the interview was not distressing. At the two-week follow-up, he repeated that "it was fine, glad I could help with the research". An email from Ed's mother also stated that there were no issues following the interview.

In-text reference:

Ed: *[Mac 17, 2 yrs]*

LOCATION D

Location D was an inland town in south-western Australia, located on a major waterway and approximately 260 kilometres from the nearest major city. The location was historically a busy trade route and major transport link, and had a geographic area of 310 square kilometres. The population was approximately 44,896 people, with a youth population (aged between 10 and 24 years) of 16.5% compared to the national figure of 19.7% (ABS, 2011b). The IRSD score was 1003 (Public Health Information Development Unit, 2014).

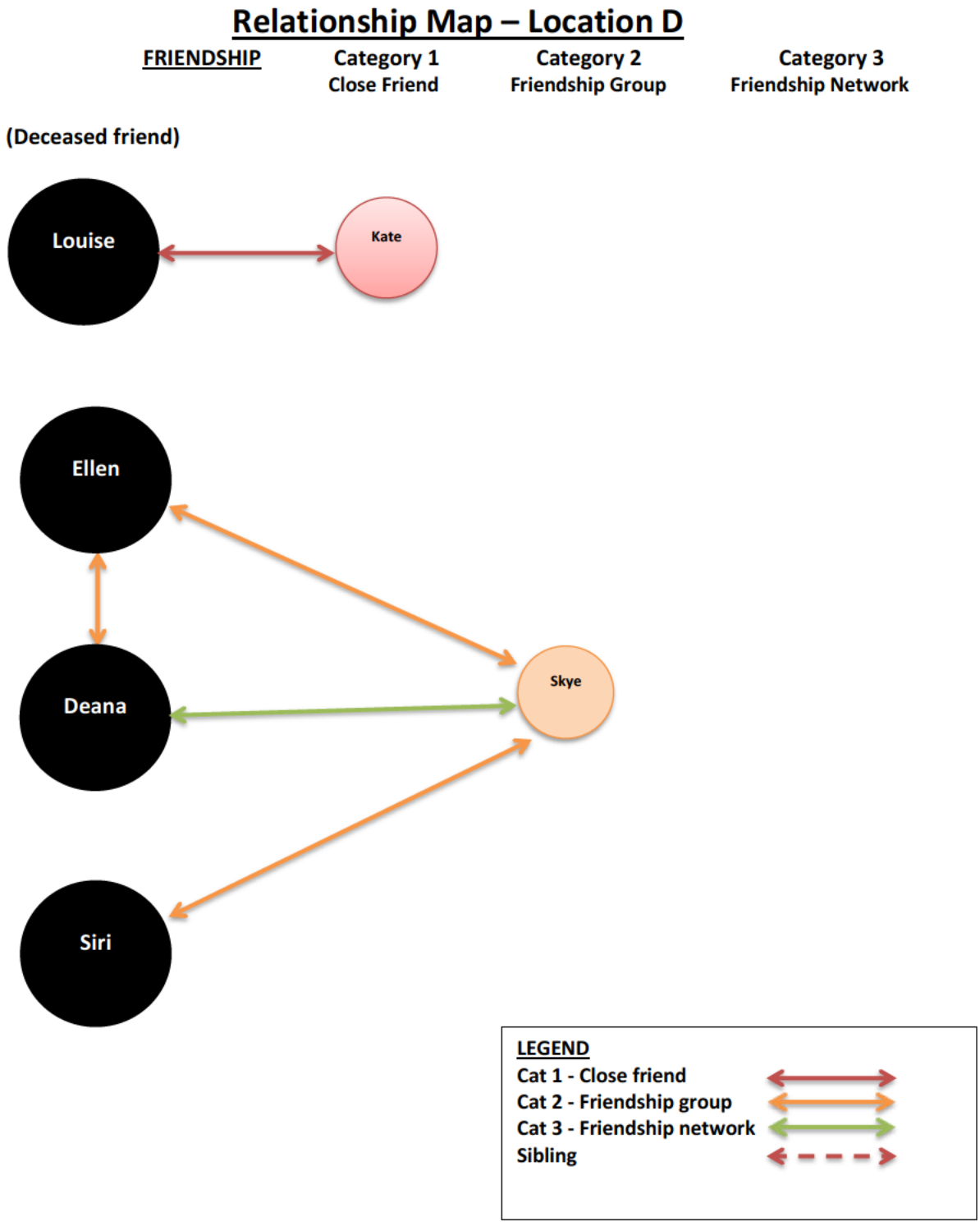

Figure 4.4 Relationship map Location D

KATE—(Louise)

The rural town of Location D had experienced a number of youth suicides over the previous three years, including one death from a high profile family. This had generated a local media campaign to promote greater awareness of youth suicide. The father of a potential interviewee had read information about the research and contacted me to say that his daughter was keen to participate; he also knew at least two other young people who had lost a friend to suicide. This father also arranged for me to contact a local psychologist with links to the local Australian Psychological Society (APS) branch. Through this contact I was asked to present my research at a local branch meeting. This meeting included a number of school counsellors who subsequently emailed me advising of a number of young people who had experienced the suicide death of a friend–they thought these young people would be keen to be involved in the study.

A story about the research was also featured in the local newspaper and, with the media campaign about suicide awareness, I felt confident that upwards of ten young people might be interviewed in Location D. However, subsequent emails from school counsellors identified that at least four young people had withdrawn

from participating stating their feelings were “still too raw” and that “they were not keen to participate”.

Kate was the first of two interviews held in Location D. Her mother had made email contact with me after reading the local newspaper article and was hopeful that Kate would agree to participate. Kate did agree and we met in a local café.

Kate was now twenty-two years old and her friend Louise had died by suicide just under eight years earlier. Kate told me that she and Louise had been best friends from an early age. They had lived in the same street and their mothers worked together *so I’d ride my bike to her house or she’d walk up to mine and we would do that pretty much every day after school or something.* They also went to the same high school and, when Kate moved out of town, they would continue to *catch up every now and then mostly through school.* However, about 12 months before Louise died, she had troubles with school and was not there as often *and from there it sort of went downhill*. Then, about six months before she died, Louise had been bullied and had become more rebellious. The school suggested that Louise take a break from school to *see what happens sort of thing.* Louise was then in Year 8 and their mothers remained in constant contact.

Kate saw Louise about a month before she died and they were *just hanging out, and being teenagers sort of thing;* she had no sense that Louise would take her own life. Even now, Kate had *gotten to the point where I have accepted it, but, I had no idea of the extent of how bad it was.* Kate first heard the news from another mutual friend who had come to school upset. When she told Kate that Louise had hung herself, Kate said she drifted through the day *like my mind was a blank in that point, and I don't remember probably much of that week between that day and the funeral.* Kate missed days from school up to the funeral and then, while *everything went back to normal,* it still remained a blur and her school work declined: *like I was a square, a nerd in high school and from that time my work went downhill.*

The school provided counsellors and teachers offered support, which lasted for about seven months after Louise had died. However, Kate said her teachers became concerned about her and contacted her mother because Kate appeared increasingly distressed and continued to remain affected by the death. On reflection, Kate said this was because she was feeling a lot of guilt following Louise's death: *I'm a very emotional person in general and that hit me really hard.* This consisted mostly of her own guilt: *what I could have done. What I could have said, could have contacted her. I could have called her that day sort of thing*. Kate also had trouble verbally expressing how she was feeling and that she was also struggling with her own *self-identity at*

the time…and then having to deal with that as well, it was a lot. Kate said her other friends tried to support her but they got to a point where *they didn't understand how they could help me, sort of thing. We just didn't talk about it. It became a bit of a taboo subject.* Kate said the *turning point* for her came from her own family and her mother and her sister: *we became closer in that time.*

Many of her other friends used drinking alcohol as a means to initially cope with the suicide death, but Kate did not: *like just I wouldn't drink at 14, it didn't even cross my mind.* Kate did start drinking alcohol when she was 16 years old. She also took into account how other people were dealing with the death–*I made sure that they were okay but as a result I neglected myself sort of thing*–but failed to acknowledge how she was feeling herself. She withdrew from others, *not wanting to see people, not wanting to do activities.*

While it had been nearly eight years since Louise had died, it was only on the night before our planned interview that Kate had talked with her mother about Louise's decision to take her own life. It had *taken a lot of time for me to not be angry at her* [Louise]. She understood that Louise was scared, hurt, and lost and that *she didn't know what to do*. Kate had also experienced this *so I know what she was going through*

to a degree. Kate now felt that Louise's decision to take her own life was not selfish and was able to respect her decision.

The whole concept of suicide was foreign to Kate at that age: *I hadn't been directly affected by it but I don't recall hearing about suicide before this happened*. Suicide then, and now, was still a taboo subject *and not something you talk about because, like, there, it's not right to feel like that, it's selfish they shouldn't have done it, that sort of thing.* The subject of suicide distressed her, but Kate did not understand the extent of this distress or the impact at the time: *especially in the aftermath of it* [the suicide] *happening I didn't think that I could get to this point. I did not see me going past probably the age of fifteen, sixteen.*

With hindsight, while she did not know whether Louise had been diagnosed as having a mental illness, *I know she was depressed.* Kate reasoned that this was as a result of the bullying; Louise knew how to mask her feelings, but Kate felt guilty that *no-one knew how it was affecting her.* Kate was positive that community attitudes had changed over the last few years and that, while suicide might not be accepted as such, it was *talked about a lot more easier, and there are more support services or support information for people out there.*

Kate was now more positive about how suicide was considered in the local community. She talked about the local media campaign and that her own life had changed; she had *become more grateful for what I have and what opportunities I can have.* Kate's own turning point came with a teacher who read one of her poems and then discussed this with her mother: *I saw how scared mum was, and then that was like, oh she's my friend* [Louise] *but holy shit this is really real, I've got to do something about this.*

Kate reflected towards the end of the interview that, while she had struggled with Louise's death, she had been able to listen to another of her friends who expressed suicide ideation to her. She had been able to tell someone about this friend's ideation, but this was *one of the hardest decisions I had to make. Because when you are fourteen, and your best friend turns around and says I want to kill myself but don't tell anyone, like, and you're feeling the same, it's scary.*

Kate told me that the interview had been fine for her and that she enjoyed the opportunity to participate. At follow-up Kate reported that she had not "experienced any negative side effects, if anything it has relieved me somewhat".

In-text reference:

Kate: *[Louise, 14, 8yrs]*

SKYE—(Ellen, Deanna, Siri)

Skye was the second, and last, interview conducted at Location C. The interview was planned to occur at Skye's home where she lived with her parents. Her father was overseas at the time. Prior to the interview, Skye's mother told me that both Skye and herself "felt that they may get teary and upset talking but we trust you". It was a warm Sunday afternoon and Skye and I located to a back deck to sit under an awning to shield ourselves from the bright sunshine. Skye's pet dog, an elderly Pomeranian, joined us for most of the interview.

Skye was aged seventeen years and in Year 12. Skye told me she had lost three friends to suicide over the last two years; two of these were good friends and one was the mother of a good friend. Skye first talked about Ellen whom she had known since primary school and who had died two years previously. She and Ellen would often sit in a small group during those early years at school.

Skye recalled that Ellen had some type of eating disorder, and that she had last seen Ellen a couple of days before she died; *but didn't think she was in a state of mind like that, yeah.* The next day the school called the students into the performing arts centre area where the principal was in tears. She said that Ellen's closet friends were

taken outside to be told and others were told at the assembly. The news that Ellen had died by suicide had left Skye *really shocked I didn't think she would actually go and do it.*

Skye recalled that Ellen had a fight with her mother, where her mother had threatened Ellen with force-feeding if she refused to eat. Early the next morning Ellen went to a bridge on the overpass *and she climbed the suicide fence and hit a truck.* That morning, the local news reported a story about a car accident and others pieced the story together. Facebook generated much discussion between people who did not even know Ellen. Here, other people posted information that they were best friends with Ellen and *saying that she was the best person in the world, she was, but yeah they didn't know that.* It really disturbed Skye when *people who like threatened to bash her a couple of months before were saying oh I love her. And just, they didn't even know her name beforehand were saying how much they were going to miss her.*

Skye then spoke about Deana who had died about one year earlier and who also attended the same high school. Deana had *some mental issues* but Skye did not realise how severe these issues must have been. Deana was also a friend of Ellen, although they were not best friends. Deana had died by deliberate suffocation from a gas outlet after locking herself in a small room. Afterwards, Deana's father posted

a picture to Facebook of *Rest In Peace Deana* and this was seen by many of her friends. Other friends then found out about her death the next day at school.

The school responded in similar ways to the death of both girls by providing counselling support and time out. This approach lasted for about a week, then *they started pushing routine maybe a week later, a couple of days, just because they know that keeping routine will keep you in order.* Even though Skye was closer to Ellen, Deana's death affected her more: *I was more sad about Deana, I don't know why but I cried more for Deana.*

Skye also spoke about the death of Siri, who was the mother of a friend. Skye was less affected by Siri's death *because I knew her better and it was sort of you know half memories. I will always have those.* Skye said that because her memories of Ellen and Siri were stronger, she was less upset about their death. However, Deana she knew less well, *so it's sort of sad I will never get that chance to see her again.*

Skye's experiences of suicide had changed the way she now considered others; it did *make me think about the concerns of others more, and that I shouldn't judge their life.* Skye also recollected that the death of another young person from her school, who died from natural causes, had been handled in a totally different manner by the

school. Here, the school just told each class separately rather than a total school assembly, as occurred with the suicide deaths. Skye found this different approach annoying; while counselling had again been offered, *there's one response to suicide death but when it comes to natural death there's a different response*.

As the community had experienced a number of youth suicides, Skye's school had been nicknamed *suicide high*–a term she found both offensive and embarrassing. That said, Skye acknowledged that, overall, the local community had managed the recent suicides *pretty well in the past* and she was less caught up in negative views about the impact and stigma that can be associated with suicide in small towns. Skye was confident about the range of services on offer in the local community and the recent push to establish a headspace centre was identified as a strength that had the potential to open up discussion.

At the conclusion of the interview, Skye stated that talking about her friends' suicide deaths had been okay, not like she had initially expected: *no, it wasn't difficult. I am just worried that what I say could be wrong or not good.* We discussed that Skye's own experience was not for anyone else to judge—her contribution was very important. At the two-week follow-up, Skye's mother said that Skye had been fine

following the interview and she had no issues of concern for her. She then wished me luck from the family saying that the "research project is so valuable".

In-text reference:

Skye: *[Ellen, 15, 2yrs; Deana, 16, 1yr; Siri, 35, 1yr]*

Summary

The initial intent of this study was to interview up to thirty young people living in rural Australia about their experience of losing a friend to suicide. The preparatory planning to attend the four rural locations suggested that upwards of forty young people might be interviewed. For reasons highlighted in this chapter, the final number of interviews was reduced to eighteen participants from four different locations in rural Australia, recruited over a six-month period.

This chapter has presented a brief description of these participants and their interview experience concerning their friend/s who had died by suicide. Some of the complexities about their interpersonal experience of suicide have also been presented. The following chapters detail the results and discussion about the qualitative and quantitative findings from the interviews.

Chapter 5

RESULTS

This chapter presents the results from the current research project that involved 18 participants from rural Australia who had experienced the suicide death of a friend, or friends, in the rural location where they lived. A mixed-methods design of QUAL + quan (Morse & Niehaus, 2009) was undertaken for the research which aimed to explore:

1) *How do rural young people live through and with the suicide death of a friend?*
2) *Are there adverse and/or positive outcomes associated with being exposed to a friend's suicide death?*
3) *Do young people have suggestions for ways in which they need support following this event?*

Both qualitative and quantitative results are presented. The qualitative results are presented first with themes drawn out of the data using thematic analysis. The quantitative results are then presented, examining the participants' measures of mental health and wellbeing compared with the general population.

QUALITATIVE RESULTS

The first theme discussed is communication about the death and the how and what participants were told about the death of their friend. This theme comprised communication by social media (Facebook), but also schools and rumours. The second theme is the response to the death and includes how stigma manifests in rural communities as a response to youth suicide. The second theme comprises three sub-themes: schools, family and friends, and the local community. The third theme is coping after the death and how participants made sense of their grief, as well as the ways in which the death of their friend impacted them. This theme comprised a number of elements such as isolation from others, alcohol use, suicide ideation, their own entitlement for support, and closer connection to their friends.

Theme 1—Communication about the death

This theme comprises the context of and manner through which the participants found out about the suicide death of their friend, and how communication continued after the death. Almost all of the participants had had (relatively) recent contact with their friend in the period prior to their suicide. Twelve of the participants spoke of having had contact with their friend during the week before they died, with seven of these having seen or talked to their friend on the day or the

day before they died. Five participants had had contact with their friend within the month leading up to the death and one had contact in the previous fortnight.

Seventeen of the participants stated that neither they, nor their friendship group, had any notion that their friend might take their own life. One of the participants was aware that her friend had self-harmed but she did not anticipate her death even though she was aware that there had been a suicide in the family:

Rachel — *I knew that* [Matilda] *used to cut herself and she used to write a lot of poems but I never thought she would take it to the point that she did. Her dad had committed suicide himself about six months before she did and I think that's what influenced her.*
[Matilda, 14, 2 yrs; Neil, 17, 1 yr; Bob 20+, 1yr; Chris 20+, 1yr]

Most commonly, the participants described their friend as a happy person who enjoyed life. John's response provides a typical example of this**:**

John — *He seemed like a real happy person, he was always happy and cheerful and I was really so surprised when it happened.*
[Dan, 19, 3mths]

While John's comment relates to Dan's emotional state, others offered different perspectives. Zac, who was also a close friend of Dan, described him as a risk-taker. This demonstrates how different friends can have different perspectives on the same person. When Dan had previously talked to him about suicide, Zac had

dismissed the idea. Yet, the night before he died, Dan posted a Facebook message and Zac knew then that Dan intended to kill himself:

Zac *But I knew that night when he put up that status he was going to do it. I knew it.*
[Dan, 19, 3mths; Vanessa, 19, 2wks]

Social media

Almost all of the participants reported the use of the social media platform Facebook as the primary tool used to communicate news about the death. This was either through initial advice posted by friends or family that the death had occurred, and often in the form of RIP with a name attached, or, in subsequent posts or status updates in the hours and days following the suicide death, or, both. Most participants reacted with shock and disbelief when they saw the Facebook status posts. Amy's reaction was typical of most on learning of Rob's death:

Amy *The first time I heard about it, I was on Facebook and I saw a post by a friend of mine and it said* [Rob's] *name and rest in peace, and I read that thinking; what, what do you mean?*
[Rob 15, 22mths; Ruth, 21, 1yr]

Following such posts, there was usually a frantic exchange of social media connectivity as the participants began searching out other friends in their networks to determine what had occurred and who else knew about the suicide:

Sue *Well at first I was like, what are you talking about? Like not, it didn't happen, and then she was no, seriously it did, and then the kind of like, going back to school, for ages I didn't like think*

much of it, and then all the time it kind of kicked in a bit, and then I was like, like I had to tell people, because like one of my good friends was in Sydney and I don't know, he wouldn't have heard the news and he was really close with Carlos. So I had to call him and tell him and I was just like kind of talking to everyone trying to work out what actually happened.
[Carlos, 14, 2yrs]

For Bronte, accessing Facebook for information became an obsession in the days after the death and then well beyond the death to gauge how other friends were reacting and coping:

Bronte *Reading the Facebook page, reading anything we could about it, we didn't believe, it was so hard to believe* [Dan] *would actually go that far. It was probably reading the Facebook page to see what everyone else was up to, what they were saying and how they were coping with it and stuff.*
[Dan, 19, 3mths]

Sue highlighted that Facebook was an essential means of communication for friends who were not in physical contact due to the school holiday period. However, Facebook also provided a source for the spread of rumours and mixed messages, with posts by other people who were not considered friends. This made it difficult for others to comprehend or understand what had occurred:

Sue *Mainly on Facebook cause we were all on holidays, but then, like Facebook you just see posts and that's, the stories all sort of got twisted so like when the police came out it set it straight for us we all still didn't really know like exactly what, why or what. Yeah on Facebook like, that's where most of the rumours were, and people were saying like yeah they was hunting, there was like this, or other options and then, some people were saying suicide and others were*

like no that didn't happen, don't say that, you can't like, it was an accident sort of thing, and then it came out.
[Carlos, 14, 2yrs]

The broad reach of Facebook, and the manner in which young people connect over social media and compete to attract friends to their own page, also meant that information about the suicide extended further than just family and close friends. As a means of social connection, other people would submit posts to the Facebook page of the young person who had died or they would send posts to close friends and family to convey support:

Mick *I found that a lot of people were there that I didn't even know. They were just sending me messages on Facebook, saying they were there, like I think in the first week I had something like two hundred and something messages*
[Peter, 14, 2yrs]

Sometimes, however, Facebook posts were seen as negative and harmful, especially amongst the closer friends of the young person who had died. While some posts contained negative comments, more frequently posts were perceived to be damaging when close friends saw others exaggerate their friendship with the deceased. In some cases, posts were made by people who were regarded by the participants as not knowing the deceased well, or even at all:

Skye *Ahh Facebook, was stupid. A lot of people who didn't know* [Ellen] *beforehand, didn't even know her name, didn't know her as a person, were saying that they were best friends, and saying that she was the best person in the world, she was, but yeah they didn't*

know that. And saying oh yeah, we're going to miss you in this class, going to miss you in this, you know. They didn't know her, and it really annoyed me. I'm not sure about everyone else but it annoyed me when people who like threatened to bash her a couple of months before were saying oh I love her.
[Ellen, 15, 2yrs; Deana, 16, 1yr; Siri, 35, 1yr]

Ed also discussed other people who made Facebook posts after the death indicating closer relationships with the deceased than Ed perceived. He explained this with regard to some young people who had bullied his friend prior to his death and that making such statements was perhaps their way to atone for their behaviour, although the motives for this were primarily self-focused:

Ed *I don't know, maybe themselves, make themselves feel better about themselves that they didn't actually, I mean when they could have done something they didn't, but in their mind they could have done something. Well in their mind they were doing something but, I mean even with the boy, that's like, to make them seem like, everyone knew that they were giving him shit in the playground but, yeah, and but they still said oh no we were good mates and we talked and things like that and saying, but everyone knows for a fact that you boys had it in for him.*
[Mac, 17, 2yrs]

Ben echoed this same concern but explained that he understood the comments from others who exaggerated their friendship were about these other people expressing their own grief, irrespective of their closeness to the deceased. Despite this, he recognised that these types of comments could lead to tension and aggression between close friends and family and others:

Ben *I know that there was a bit of tension there because there was obviously the whole Facebook thing and…I think there was some, whether they were girls or boys, that were in a way acting like they were, they were obviously grieving themselves, but they were acting like they were better friends with* [Peter] *than what they actually were and I think, especially with his sister and a few of his really close friends, like they were quite agitated at that and I know even there was one girl that was writing, whatever she was writing on Facebook, but the sister, the sister said she wasn't even going to go to the funeral if she was going to be there, and she was also saying like…where they had the wake and she said if she shows up here I'll be telling her to leave straight away, so that kind of aggression.*
[Peter, 14, 2yrs]

Alternatively, and as Skye explained in relation to a less close friend who died by suicide, losing someone you only know in a superficial or limited way is upsetting because of a realisation that you will now never get to know them:

Skye *I think I didn't cry as much for Siri because I knew her better, and it was sort of you know half memories. I will always have those. It's nice to reflect on that, and, she's always in my thoughts. But with Deana I think it was crying for sense of I didn't get to know her. I didn't get a chance so it's sort of sad I will never get that chance to see her again.*
[Ellen, 15, 2yrs; Deana, 16, 1yr; Siri, 35, 1yr]

Others observed that Facebook posts were occasionally made by people with the intention of being overtly inflammatory to others, for reasons unbeknownst to them, which had the potential to cause distress. Some, like Belinda, reacted angrily to these posts:

Belinda *It was all posted all over Facebook. Someone wrote like get over it,*

she was just attention seeking, yeah. It got me so angry, I punched some little kid out from that.
[Michelle, 21, 3yrs]

Others, like Lauren, were distressed that people would use Facebook to promote their own negative or derogatory views about the deceased when, in fact, they understood little about why the person chose to take their own life:

Lauren *People said that* [Dan] *was like a deadshit anyway. Some people were really mean about it. It was upsetting to read those types of things because it just showed how selfish some people can actually be, and not realise that this person has issues and couldn't take it anymore so he took his life. A lot of people don't understand.*
[Dan, 19, 3mths]

In some situations, the potential for posts on Facebook to spiral out of control and be a major problem was recognised by others. Skye stated that her school had picked up on this concern fairly early and instructed its students to not publicise or make posts about the suicide death on Facebook. Of course, in reality, the school's jurisdiction to be able to prevent this was limited and posts continued to be made:

Skye *I know the school said don't publicise it on Facebook. Straight afterwards we got told and that was like fair enough, other than rest in peace which was okay. But then they started writing paragraphs with Ellen rest in peace and it really got out of hand.*
[Ellen, 15, 2yrs; Deana, 16, 1yr; Siri, 35, 1yr]

Two participants (Bron and Amy) spoke of the deceased friend's Facebook site being monitored or moderated by parents and this seemed to ensure that posts

made by others were appropriate, and not divisive or critical. For Amy, the deceased's Facebook page became a memorial:

Amy — *I know Rob had a Facebook page that was taken over by his family. And they made it a memorial and in the first few months we would post photos and memories and that was something positive that we can go back to.*
[Rob 15, 22mths; Ruth, 21, 1yr]

Memorial sites for the deceased friend were acknowledged as a significant and positive way to maintain connection. Skye explained this about a memorial site created post-death:

Skye — *I know that one girl, she set up a Facebook page for* [Ellen], *like a memorial page, but that was you know, fine, that was controlled and everything, and all those people who wrote it knew her as well, so I didn't have a problem with that site.*
[Ellen, 15, 2yrs; Deana, 16, 1yr; Siri, 35, 1yr]

While many of these Facebook memorials were useful, other uses for memorialisation were less comfortable. For example, Belinda was more ambivalent about Michelle's mother posting photographs on the Facebook page. She expressed some discomfort that she found hard to express in words:

Belinda — *Yeah, it's sort of a good thing cause her mum always posts photos of her up there, all the time, I don't know it's just weird, I don't know how to put it.*
[Michelle, 21, 3yrs]

Other communication

Although a primary means to communicate about the death, Facebook was not the only manner in which participants were informed about their friend's death. Given the sample was drawn from small rural and regional communities where the majority of the young people who died attended the same school, or another school in the same location, news about the death was also communicated by family, friends, and the school. Rachel talked about being aware that something had happened with her friend Matilda but it was not until the next day at school that she was told her friend had died by suicide:

Rachel *We lived in a very small town so anything that happened you would kinda feel, me and my mum walked out the front and up the road and I seen them pull up right outside Matilda's house. I didn't know what to do. And I wanted to go up there and my mum wouldn't let me, she's like no. And then the next morning she didn't come to school and they never told us anything...we didn't find out until about 10 o'clock it would have been.*
[Matilda, 14, 2 yrs; Neil, 17, 1 yr; Bob 20+, 1yr; Chris 20+, 1yr]

Kate also found out about her friend's death via another friend at school:

Kate *One of my other friends, who was mutual friends, heard about it before I did. She came to school upset and I said what's happened. And then she told me and I don't remember going from the school oval to the classroom. Like my mind was a blank in that point.*
[Louise, 14, 8yrs]

Regardless of how participants were informed about the death of their friend, most felt an ensuing need to find out more about what had happened. This generally commenced with communication amongst each other, whether using social media or direct conversation. The participants were mindful of the potential for rumours and gossip to quickly spread. They reported being cautious to check with each other what was known and not get caught up in malicious gossip so as not to offend their friend who had died, their family, or other close friends:

Amy *We had rumours from, everything from,* [Rob] *died because he deserved it, and a lot us really didn't know why he committed suicide, and there were other rumours about where he'd been dared to, or he'd gone out and was doing it as a joke and he didn't think he'd go that far, but a lot of us didn't understand what was going on at the time so it was more of just playing it by ear and listening to stories trying to explain it to someone else and hope that they wouldn't misinterpret it. I know a lot of friends of mine would go this is the story we know, what do you know, and we'd add it up and try and make some sense of it because we were hearing totally different things and there was no group sit-down and this is what actually happened guys*
[Rob 15, 22mths; Ruth, 21, 1yr]

The view that the suicide death was probably inevitable was spread through these informal communication channels. However, it was generally spread by those who were less close to the deceased. This caused distress to close friends who were more likely to know the true story about what had happened, but did not want to engage with others about it, as Adam recalled:

Adam *I find that people soon as they hear about it, that spreads around*

like a week or two, and different stories get muddled up. There's the need topic of gossip. Like at high school they have to have something to gossip about. Like, they weren't directly close with the boys, so it's just another bit of gossip they can just spread around and then sit. Then you've got the guys who are actually close to them and they have still got to deal with it kind of thing.
[Peter, 14, 2yrs]

Bronte also stated the view that, while there was a desire to find out more about what had occurred, there was a need to respect those most impacted, over and above a personal need to know more:

Bronte *We didn't find out any more, but we talked and asked a few questions with friends. We didn't really talk to anyone cause we weren't sure, we didn't want to upset anyone anymore so we thought we would respect them by not talking*
[Dan, 19, 3mths]

This view of not wanting to upset anyone anymore reinforced necessary communication about a friend's suicide death using Facebook and informal communications. This provided a way of finding out what had happened, telling other friends about what had happened, as well as monitoring how other friends are dealing with the news, without necessarily being intrusive on those closest to the deceased. While participants found Facebook useful in this way, its openness and accessibility in such situations also led to problems such as rumours and malicious gossip. Meanwhile, traditional spoken communication among small

communities also kept a steady stream of information (both accurate and inaccurate) flowing following the death.

Theme 2—Response to the death

The narratives of the participants are threaded with their perceptions of how the local rural community responded to the suicide death, and to the participants themselves following the death. Each of these are considered subthemes, and are addressed separately commencing with schools, then family and friends, and then the local rural community in general.

Schools

The participants for this study were primarily high school age. Therefore schools were a primary focal point for responding to the initial aftermath of the suicide death. For some schools it was the first time a suicide death had occurred among the student body. Schools are part of the broader community and, as such, are likely to reflect much of the local community views and values about suicide. Participant narratives demonstrated considerable variation in the manner in which their school communicated news and details about the death. This was also evident in the support provided following the death. There were also differing viewpoints between participants at the same school in regard to the response to the same death.

The response from schools also depended on the number of deaths the school had previously experienced and, in some instances, the type of death.

Some schools chose to communicate news of the suicide death to the entire school assembly with largely unstructured follow-up immediately afterwards. This was Ben's experience following Peter's death:

Ben *I know that they sort of pretty much, they sat the whole school down as an assembly when the school had resumed and said that if at any time people need to leave class or go see the school counsellor.*
[Peter, 14, 2yrs]

Other schools addressed the entire school assembly but chose to have external health professionals deliver the news. In an example provided by Sue, the local police first spoke to the whole school and then offered smaller group sessions afterwards, with the police at the school, where more questions and details could be sought. In this case, the police presence reinforced the seriousness of what had occurred and the explanations and details provided by the police also helped to dispel rumours. Sue's story also suggested that the school was being proactive in case there were concerns for other young people. From Sue's account, it appears the school had done some planning about how they would approach responding to the suicide death prior to delivering the news:

Sue *But before that was an assembly sort of thing and the police were*

like, this is what went down and then if you wanted to ask any questions then come and talk to us… it was like saying that this actually happened like, the police are involved, it's really serious. Yeah they did in front of everyone but then if you like went to them and asked them more questions they like gave you the full details...and if it made you upset they were like yeah well this is the facts sort of thing. I think it was alright for most people. Like, because there was the answers if you wanted them, then people could like stop wondering and like stop, like with all the rumours going round it stopped people like thinking of a worser option or like something worse happened.
[Carlos, 14, 2yrs]

Other schools also chose to address communication about the death to more specific groups, such as the class or the year cohort of the student who died, but there appeared to be no clear structure for follow-up immediately after the news was provided:

Ed *They called our grade cause obviously we were in the same grade as* [Mac]*, into the chapel which was a part of the assembly room, or whatever it's called, and they just told our grade with a few teachers and that, and yeah, the rest of the day pretty much you were able to go to your classes or stay at school or go home.*
[Mac, 17, 2yrs]

Amy reported that her school seemed to take an active stance of denying that the student had died by suicide. Amy also inferred that the school limited the availability of counselling support:

Amy *The school were forced to admit it in the end, because it was a year 10 student. The students all knew who it was and what happened, so they had to give in and say okay we're going to not deny it. They had a group counselling session, so you could go in with others to a*

counsellor and they had I think one or two sessions and that was it
[Rob 15, 22mths; Ruth, 21, 1yr]

Ed also suggested that the motive behind the school's response seemed to be about protecting the reputation by limiting engagement and knowledge about the suicide, which he found frustrating:

Ed *A few people got frustrated with the school in their handling of the, because they kind of tried to deny it, or not deny it but, yeah completely very, well evidence of it ever happening but everyone knew what happened, but they tried to kind of like carry on with their day and the school tried to, wouldn't want to damage their image of course. That's what they were like, that school.*
[Mac, 17, 2yrs]

Adam was dismissive about his school's response to the suicide. He felt the school was tokenistic towards the family of the young person and to his friends at the school who were impacted by the death:

Adam *Usually the standard things is, like they, the school says a big apology to the family, and, all their thoughts are with them, and then they offer kinda counselling for anyone who was actually close to them, and take them stuff, like they might get the parents together, they might ask people's parents to make some dinners and stuff for them and send over to the families so they don't have to cook and stuff like that, little things like that. Like, personally I think schools could do something a lot better, instead of just sending out the odd dinner basket to the family, like actually get big group counselling or something like that or even have a class outside where you can actually talk people's feelings about stuff and go through it.*
[Peter, 14, 2yrs]

Brad objected to his school offering a biased picture of Carlos, saying what a great and valued student he was. Brad found this exaggeration deceitful and would have preferred the school to be honest in their presentation of Carlos because this would be a better way to remember his friend:

Brad *I know at the school they would go on just in general about Carlos as like, a loving student, he was their favourite student, and that. They liked him as a nice student but he wasn't a class 'A' student. He'd would muck around with his friends and that, and they'd never, they'd tell us all, they'd over exaggerate how good he really was. I would have liked for them to say stuff about Carlos like he really was, remembering him for what he really was, not something else.*
[Carlos, 14, 2yrs]

However, not all responses from schools were seen as negative. Amber, for example, reported that she felt the way her school responded was appropriate. Here, the school had continued to support their students and they also allowed for the student who had died to continue to be acknowledged into the future as a continuum of a memorial or remembrance for Carlos:

Amber *I think it was good what the school did. Like just getting everybody together to talk…and on the first day back they spoke about it at assembly and stuff. And also now at school every year now on his birthday, or around the time of his birthday, me and my friends we have a memorial thing in the hall and people just get up and speak. And we have this thing where we write letters and then we burn them.*
[Carlos, 14, 2yrs]

A number of participants said that their school targeted the delivery of information and interventions for friends who were known to be, or that the school identified to be, closer to the deceased. For example, at Skye's school, the deceased young person's friends were told separately to the rest of the school. Skye speculated that the school had probably worked out who the main friendship group was, based on their knowledge of the student who had died:

> *Skye* — *And I remember, everyone was sitting in the PAC* [performing arts centre] *and the principal was crying. Then* [Ellen's] *group of friends got up and they were taken outside, obviously to be told, and then they told us, and it was just utter silence, people crying, but just utter silence. I think, she was such a well-known person at school, she did a lot of sport and she was very academic, so I think they knew who her friends were around lunchtime, so I think that's how they knew.*
> *[Ellen, 15, 2yrs; Deana, 16, 1yr; Siri, 35, 1yr]*

Kate said that her school also offered specific supports for close friends over and above what was offered to students in general, however all students were offered support:

> *Kate* — *There would be like a separate room where if we were having difficulty we could go at any time of day and just sit or talk or whatever. We'd make appointments and there would be other teachers who would not so much counsel us but be there for support and say alright, I can see you are having issues or something. Come into the classroom and we'll chat about it...but mostly the people who were sort of close.*
> *[Louise, 14, 8yrs]*

Amy said she was aware of the school response of both high schools in her town because of the communication from friends attending both schools. Both schools offered different support options. Amy was critical as she felt that the schools based their responses on who they felt needed support, which was detrimental to other students who missed out:

Amy — *I think it may have been better to offer both the groups single sessions for both schools instead of only offering to the people they thought were affected.*
[Rob 15, 22mths; Ruth, 21, 1yr]

After the initial delivery of the news, the participants' schools generally provided access to school counsellors for students affected by the death. Whilst some schools relied on existing staff, others brought in additional counsellors to help:

Skye — *The school did offer a lot of counselling, I know there was a lot of counsellors in the language centre and they did employ a lot more afterwards.*
[Ellen, 15, 2yrs; Deana, 16, 1yr; Siri, 35, 1yr]

However, students generally needed to be proactive in seeking support from counsellors:

Adam — *They sat the whole school down as an assembly when the school had resumed and said that if at any time people need to leave class or go see the school counsellor, cause I think they actually bought a team of counsellors in for the first week or two, after it happened so they were there.*
[Peter, 14, 2yrs]

Some schools chose to provide one-on-one sessions, group sessions, or sometimes both. However, this was often time-limited and students felt restricted for choice:

Amy — *I know they had a group counselling session, so you could go in with others to a counsellor and they had I think one or two sessions and that was it. At* [school] *they had single sessions so you could book it in with their guidance counsellor so that was only for a limited number of them, it was very limited access, you actually had to approach yourself, the counsellor yourself, if you wanted to go with that, and there was no option of if you were friends at* [school] *of getting anything different, it was, you were given two options, you could go to the big group one or you could go to the single one if you were at* [school]. *At my school they only offered the group counselling.*
[Rob 15, 22mths; Ruth, 21, 1yr]

Belinda reported that, while there was a counsellor available at her school, she chose to not talk to anyone because doing so would be admitting her friend had died and she could not, or would not, accept this at the time. Talking about the loss would have done this and so Belinda chose to avoid support. However, she now regretted this and recognised it would have been better to speak with someone:

Belinda — *They like wanted me to talk to a counsellor but I couldn't talk about it, didn't want to talk about it. I just didn't want to talk about it at all. I didn't talk about it to anyone till about a year after her death. If I had spoke to people about it earlier. I can talk about it now no problem, but then I just didn't want to accept the fact that she's gone. I didn't want to let go.*
[Michelle, 21, 3yrs]

Other participants talked about the role of their own school when the deceased friend attended another school. For example, John attended a different school to Dan and he perceived his own school was unaware of his friend's death:

John — *I didn't talk to them that I was upset. They still don't know, I don't let people know that I'm really upset, I just keep it to myself altogether.*
[Dan, 19, 3mths]

While this is John's narrative about his experience at school, it is interesting to note that John came to hear of the present study through the school counsellor, indicating that at least the counsellor was aware of John's bereavement following Dan's death.

Nadia's friend who died by suicide did not attend her school. It was only after Nadia had missed a couple of weeks of classes, and the family had spoken with the school, that the school became aware of the bereavement. Nadia saw the school counsellor, but this experience made her feel pitied rather than supported:

Nadia — *We had to ring them as I missed a couple of weeks of school, so we called them, we had to tell them, I had to see the counsellor but I don't get on with counsellors. I think things like schools and counsellors, there is nothing they could do as they are paid to care. They treated me as if I was different, which like they pitied me, and I don't like that, like pity's not real compassion. They were pitying me more and it was obvious that they were.*
[Ruth, 21, 1yr]

As Dirk went to a different school, Bron was offered no support from her school, primarily because she was the only person who knew about his death as he lived about 100 kilometres away. With no school-based discussion, and no recognition of her grief, Bron dealt with the death by becoming closer to her friends and focusing on other tasks:

Bron *Nothing from the school, I was the only one at (school) that knew* [Dirk] *so there wasn't any talk of it. No, but I'd dealt with it in the past so just kind of like got closer to friends I had at (school) and focused on my studies and got through*
[Dirk, 18, 2yrs; Jim, 14, 7yrs; Anita, 15, 3yrs; Sally, 16, 4yrs]

The participants also spoke about their school wanting to quickly return to normal routine within the week of the suicide death. Ed spoke about his school's return to routine in negative terms. He viewed that this action was taken by his private school to hide or keep quiet what had occurred for fear this might tarnish the school's reputation:

Ed *Well I mean, the second day, it happened on Tuesday and by then the teachers weren't talking about it. Well some of them were the ones that actually knew* [Mac] *on a personal note, but the overall view at the school was come on get back to class kind of thing, which just tried to push it under the rug kind of thing. It never happened and so forth, forget about it.*
[Mac, 17, 2yrs]

Further, Sue spoke of how Carlos's suicide death also seemed to impact other decisions, such as curriculum and school-based activities. She said these decisions were made by the school without input from students:

Sue *The school tries to like, I think they tried to, like that year they made the school theme like, embrace yourself or something like that, and you could tell it was because of* [Carlos] *that they were like doing certain things. And like they, we had this topic in PE about mental health, and they were like oh we might not watch this video cause of your group sort of thing. So sort of like we knew they were doing things or weren't doing things because of it, and it kind of like was well you could let us make our own decisions on whether we do that sort of thing.*
[Carlos, 14, 2yrs]

A number of participants openly discussed that they would not seek help from school or other counsellors. In general, they preferred to keep to themselves or seek support from their friends. Adam did see the school counsellor and, while this was beneficial, it seemed more like a support group directed at students who may have been at risk of suicide. This may have been a reflection that the school was more focused on ensuring another suicide did not occur, rather than seeking to more broadly support bereaved students irrespective of whether they were expressing suicidal ideation. In this way, Adam felt that school interventions were lacking:

Adam *Yes, the school counsellor. I went to her a few times, and that was really good but, it just seemed like it could have been like a support group, or something for other guys that might actually been dealing with it but they might not have wanted to admit it as well, so might have just figured it wouldn't work. It just seems like there is not a lot around for high schools.*

[Peter, 14, 2yrs]

Schools responded differently to suicide. They differed in the manner in which they notified, identified, and supported students following a death, and the participants were both critical and sometimes supportive of these approaches.

Family and friends

While most of the participants were attending school, nearly all were living at home or with a family member when their friend died. However, rather than a major source of support, in reality, participants described very mixed responses from both their family and their friends. These responses ranged from complete support to total disinterest or ignorance about how the suicide death had impacted on them. The participants also described their own responses to family and friends of their deceased friend. The majority of participants identified that their close friends were their greatest source of support and they, in turn, provided support for their other close friends.

While Brad's school offered the school counsellor, other professionals, and telephone helpline numbers, he chose not to take up these offers. Instead, Brad preferred the support of his family and friends. While his family were also

struggling to come to terms with Carlos' death, they sought out advice from others about the best way to respond to him as well as another friend and his family:

Brad *Ahh, I don't know. I feel that I can talk to my parents and my friends and they will provide me with as much help as anyone else would…They were in denial a lot, they were in shock. They didn't know why cause they knew Carlos as a very cheerful person. Yeah, they were there for me, they were there for Mick and his family…one of my neighbours was a counsellor at one stage and they went up and asked him what they should be doing, what they should be offering and how they should be dealing with the situation*
[Carlos, 14, 2yrs]

Kate's family were also supportive, but struggled to know what to say. Kate now believed that unless someone had direct experience of suicide loss, they would not know what to say. In this way, support was limited:

Kate *Mum was great. Like she was very supportive. My sister and I have never had a huge bond, but we became closer in that time. She was there for me…and they were just there, always willing to talk. Not all the time. Because with this subject, there's not a lot of people who are either willing to talk about it or have been affected by it directly. Cause until you have been affected by it you have no idea what it's like.*
[Louise, 14, 8yrs]

Amy also sought support from her parents and they encouraged her to talk as much as possible. Her mother also became a strong support for other friends who felt that they were not able to talk with their own parents. In fact, talking with her parents,

friends, and Rob's parents, was all part of Amy's process that helped her come to terms with her grief:

Amy — *Mum tried to be supportive to both myself and my friends. But it was the sort of thing where we thought it was strange to talk about it and my parents tried to get me to talk as much as I could which I am thankful for now because it helped me come to terms with it a bit faster. And I know a lot of my friends through talking to my mum were able to, because they didn't think they could talk to their own parents, so they would talk to my parents instead…and I know a lot of my other friends, their parents weren't very receptive of trying to talk to them…probably ourselves, but we went out as a group, talking to each other we pretty much figured out amongst ourselves. But there was no real this one person helped us, it was mainly a combination*
[Rob 15, 22mths; Ruth, 21, 1yr]

Sue was ambivalent about the support offered by her family. She acknowledged that her family did not seem to cope well following the death; her interpretation of the message from her parents was that she should just get over it and move on with life. Sue said this advice was not helpful and, as a consequence, she sought solace and support from her close friends. This was more comforting than talking with her parents:

Sue — *I don't think* [her parents] *really knew how to cope like very well. In a way they were kind of like, just get over it sort of thing. But they weren't literally saying that but giving that message, like just don't worry about it sort of thing, just take your mind off it, but, I couldn't. Like it was that big of a thing at the time it was way too difficult to just take my mind off it so I think I found like talking to my closest friends easier than talking to my parents about it.*
[Carlos, 14, 2yrs]

Sue also noticed that her close friends' reactions to the suicide were very different. While one close friend had dealt well with the death, another was struggling and impacted in a major way:

Sue — *One of my friends, Tran, he was actually Carlos's best friend, he was actually planning on staying with Carlos on the Friday night. And I reckon he has changed a lot cause he is really a lot more quiet now as well…Yeah he still goes to school and like he, he says he feels okay but at the funeral he was really bad, but then he wouldn't talk to anyone about it or anything so I don't know, I think it impacted him most. And then one of my friends Amber, she was like really close to him, and they were almost dating I think around that stage and but she dealt with it really well cause it was like, the two closest people to him sort of thing, like, dealt with it completely differently, but yeah, and she seemed to be pretty fine with it now. I mean obviously she gets upset but not nearly, but Tran kind of in a way just pushes people away*
[Carlos, 14, 2yrs]

Bron also spoke about how other friends had reacted to Sally's suicide. Most of her friends grew closer as a group, although one friend became psychologically unwell:

Bron — *One of my friends she developed a psychological disorder after Sally, but the rest of them had a similar sort of reaction, we all kind of grew really close together.*
[Dirk, 18, 2yrs; Jim, 14, 7yrs; Anita, 15, 3yrs; Sally, 16, 4yrs]

In total, Bron had experienced the suicide death of four friends. She spoke about her friends and their reluctance to talk about Dirk's suicide in particular, especially the circumstances they understood to have possibly been behind his decision to take his

life. Despite the reluctance to talk about suicide, Bron said that her friends were there for her and constantly checked to make sure she was okay:

Bron *Like a lot of people didn't actually talk about it, it was just sort of something we didn't talk about. I don't know, I guess, I don't know you don't really talk about it, when it's suicide, like especially when it's like a boy doing it over a girl or a guy, it doesn't get talked about at all. I don't know, my friends that was all that was really there. They checked on me and made sure that I was okay, that I wasn't overly anxious or overly sad, they made sure to keep my mind off things.*
[Dirk, 18, 2yrs; Jim, 14, 7yrs; Anita, 15, 3yrs; Sally, 16, 4yrs]

Ben also saw Peter's friends band together as a group and support each other after Peter died by suicide:

Ben *The friends I think they were probably struggling quite a bit, but one thing I noticed was that they did, they pulled together, as like a really tight knit group of friends and that like they I think a few days after it happened they all got together down at the river, I'm not sure if it was school holidays at the time, a lot of the teachers from the school went down to see, make sure that everyone was all right, to offer them, like appropriate services if they needed it and that all that sort of thing.*
[Peter, 14, 2yrs]

Nadia however found little comfort from her friends. This was reinforced by her family's response. Nadia felt totally neglected in the aftermath of her friend's suicide. She seemed in no doubt that responses by others to the suicide did not consider or include her:

Nadia *No, my friends thought it was a joke. My friends joke about suicide, they make stupid comments... One of my family members is a real*

jerk, I would have liked it if they weren't as much of a jerk. I would have liked them to be there, allow me to talk about how I was… me, it wasn't about me, at all.
[Ruth, 21, 1yr]

Some of the participants described their own reluctance to talk to other friends and family of the young person who had died. Adam had wanted to talk with Peter's friends and family. The friends were all boys he had coached in a local junior rugby side and, while he continued some connection with them, he did not feel able to talk about the suicide with them or Peter's family. While Adam's work had prevented him from talking with the friends, he still was not able to raise the subject in subsequent meetings with them. He expressed some guilt about this:

Adam *I didn't get a chance to talk to the boys, it was their cousin, apparently they found him, so I didn't get a chance to talk to them, cause it was after the football season…and I stopped coaching for a while, cause I was busy with work commitments, so didn't get a chance to talk to the boys, and I meant to and, but didn't know how soon it would be and didn't know how comfortable the family would be with me talking about. Oh yeah I've seen them a couple of times, but doesn't, sort of not the, really the first things that comes up in conversation. I feel a bit bad about that, I didn't get a chance, I didn't really get a chance to talk to them or anything like that. Like, I got busy with my own stuff, a bit hard, like I should have really.*
[Peter, 14, 2yrs]

Kate also spoke about distancing herself and her family from Louise's family after her death, despite them having grown up together and having been very close. This

response had now continued for eight years, with Kate still uncertain about whether her presence would be an intrusion:

> *Kate* *We didn't actually go with her family as we wanted to give them the privacy of obviously grieving, cause they have just put their nearly fifteen year old daughter in the ground and no parent wants to do that. Out of respect for them we left them. Even now I didn't go round to see them, because I honestly didn't know how or whether I would be an intrusion sort of thing.*
> *[Louise, 14, 8yrs]*

The participants described differing levels of support from their family. Most chose to share their thoughts with, and seek out support from, their close friends. This was largely done on the basis of supporting their friends and in preference to seeking out more formal support. In general, the participants were mostly reluctant to make contact with the family of the friend who had died. For some there was a sense of guilt about this but most expressed that they would not be comfortable in knowing what to say in these circumstances.

Local community

The participants also spoke about their local community, especially in terms of its response to the suicide death of their young friend. Most described a reluctance to talk about or acknowledge suicide in their town. They spoke about fear and stigma, particularly in rural communities, which polarises help and support for people at risk of suicide. By and large, the participants reflected that talking about suicide

was easier amongst themselves, difficult among families–although possible, however there was more resistance among the local community. Bron spoke of the taboo about suicide and how this shapes thinking in rural communities:

Bron *Hidden, hidden always hidden. Just cause of that whole like the taboo of talking about it, like there was so many people who think that it is a sin to commit suicide, or that like people who have mental illness are just crazy.*
[Dirk, 18, 2yrs; Jim, 14, 7yrs; Anita, 15, 3yrs; Sally, 16, 4yrs]

John was reluctant to talk with Dan's family about the death. He acknowledged that he was close to the family but felt guilty talking about Dan, and this spoke to social stigma and silence about suicide in rural communities. John worried that the family might not like him discussing Dan's death with others. However, he was also concerned that talking about Dan, even amongst friends, would remind them of the pain that ensued following the death. Indeed, John's friends would actively shut down any conversation which had now silenced his own grief:

John *If their family wanted to talk about it, they'd probably talk about it themselves. Where if I'm talking about it, and they don't know that I'm talking about it, they might think poorly of me for doing it. Yeah, a lot of my mates have done that now. Like, if we are out and you bring it up, people tell you to shut up. Because it, a lot of people were really really close to him and just bringing him back up just brings back pain. I try not to talk about Dan around them cause it makes them really upset.*
[Dan, 19, 3mths]

Others, like Ben, described the shock that a suicide causes in a rural town, particularly when the family members are well known and the death is of a young person. Small towns seemed particularly vulnerable to gossip and Ben was clear that rumours in his town implicated the potential for more suicide deaths to occur. This was especially damaging when the town was so unprepared in its response to youth suicide:

Ben *I know that* [Peter's] *grandparents are held fairly highly in the community so there was a lot of support for family…it did it did shock the town because you sort of think oh, how could something like this so tragic happen in our small little town type of thing. That being a small town all the rumours start coming out that it's a bloody chain, chain reaction, and there are going to be more, and then more rumours coming and you just hope that this doesn't get back to the family but, it's sort of inevitable being such a small town. I think it was sort of something that no-one had ever really dealt with before, not the suicide, but being a youth suicide, I don't think anyone was really prepared for what to do.*
[Peter, 14, 2yrs]

Adam was critical about how other people in his community judged those who died by suicide. He felt most were quite ignorant to the plight of people who struggled with suicidal thoughts and behaviours and mental illness. Adam was also mindful that many men in his local community reflected the stereotype of the rugged macho male. He felt that these men dismissed any suggestions of personal weakness and thus did not accept mental illness as something requiring support:

Adam *A lot of people, small mindedly observe, see suicide as the easy option, the weaker option, but they, it's like ignorance, they don't*

actually get it, that some people just get that sad that it's hard for them to do it, unless they have actually lived through it or experienced it they don't get it. In this town, there is a lot of guy guys, guys shrug it off kind of thing. They, a lot of tradie men around here and they kind of laugh it off, tell them to toughen up kind of thing, have a beer and stuff like that. That's half the problem I think.
[Peter, 14, 2yrs]

Adam and his friends were also silenced by the experience of suicide and preferred to not talk about it because it was easier to handle that way:

Adam *They wanted to hang out with me and stuff but like I think you could Just tell that it would make them awkward if I bring stuff like that up. so they are just trying to avoid it I think, just cause they would rather keep me happy and off topic I think cause it is easier for them not to talk about it.*
[Peter, 14, 2yrs]

Suicide was also not talked about in Amy's town–the subject was kept quiet and support for people was limited. However, recent suicide deaths had begun to change things. Younger people, particularly, had become more open to talking about suicide despite a prevailing taboo in the rest of the community:

Amy *Prior to all of the youth suicides that we had, that was well known, both for myself and for my family having lived here for so long, it was something that they kept very quiet, and mental health* [services] *was really only directed at certain people. Whereas now more people are willing to admit that stuff happens and a lot of the older generation have been watching the younger generation grow up and they have noticed that we are more open to change. Whereas out here it's so well known, that if you bring it up in conversation, people think what of these groups, and these organisations, and we've got a network that we have had to establish, but essentially it*

is a taboo.
[Rob 15, 22mths; Ruth, 21, 1yr]

Amy also spoke about her resolve to take a stand about youth suicide. Together with her friends, she had established a suicide support page on Facebook that focused on positive interactions and support options for young people. As discussed in the previous chapter, some professionals had challenged the page but she persevered because she recognised that her friends needed support options that were not being provided in the community:

Amy *I had some pretty negative responses. Like I had professionals saying to me you don't know what you're talking about; you don't understand the psychology behind it, and it sort of makes you, it made me think, I don't need a degree to see that people aren't handling it. I don't need a piece of paper that says I have this knowledge to see that my friends aren't going to handle this in ten years or twenty years' time.*
[Rob 15, 22mths; Ruth, 21, 1yr]

Kate also spoke of how unknown suicide was to her before Louise died. In her community, the taboo of suicide was still prevalent and this restricted help for suicide or for those affected by suicide:

Kate *From what I can remember, I'd never heard, I don't know, I hadn't been directly affected by it but I don't recall hearing about suicide before this happened. And I think even then it's still a very taboo subject. But I don't recall anything being done as a result sort of thing.*
[Louise, 14, 8yrs]

Brad also spoke of how suicide was silenced in his community–people would actively change the subject rather than talk about and confront it:

Brad *They don't really want to raise the subject and when it is raised, usually they're like, we'll try and change the subject to get away from it.*
[Carlos, 14, 2yrs]

Rachel had initially lived in much smaller town compared to the other participants, and dealing with people's reactions was very difficult. Rachel described being constantly confronted with reminders about her friend from others who would talk to her. As a consequence of these conversations, Rachel had to leave the town because she could not deal with them anymore:

Rachel *They just, being a small town, having small town syndrome, they just you know, you'd be fine one minute and next you'd have people come up to you and tell you stupid things about your best friend. But after it happened I didn't go to school for about two weeks, three weeks, I just couldn't handle going back. I didn't want to hear anything. Then I moved, I moved just cause I couldn't handle being in that town anymore.*
[Matilda, 14, 2 yrs; Neil, 17, 1 yr; Bob 20+, 1yr; Chris 20+, 1yr]

Lauren said that, while people in her town struggled to talk about the death, she felt that it was important for herself and her friends to be able to talk and express how they were feeling:

Lauren *I think that, it, whether we should talk about it, and then it makes it all better you can get it out and express your feelings instead of keeping it bottled up. A lot of people can't handle to talk about it, which is very understandable, but I give them time.*

[Dan, 19, 3mths]

Overall, the participants recognised that stigma about suicide was prevalent in their towns. This stigma prevented people talking about suicide. This particularly applied to friends and families of the young person who had died, but also between themselves. Most of the participants reflected that, even though they had a more open attitude and were more willing to talk about suicide since their friend died, an element of stigma manifested in their own unwillingness to talk with their deceased friend's family members. It also was present in their own reactions to suicide and how they coped with the death, explored below.

Theme 3—Coping with the death

The participants described a range of responses to their friend's suicide. For most, the immediate response was one of shock and disbelief. While the participants recognised that they were distressed in the aftermath of the suicide death, they generally did not seek out professional support. This theme explores this to better understand the coping mechanisms these participants explained helped and/or hindered their grief. Some participants said they used alcohol to help cope with their grief; they were aware other friends also used alcohol, and sometimes other drugs, to cope.

After Peter's death, Mick was in total shock and did not want to acknowledge what had occurred. He had seen a counsellor on his father's insistence but did not want to return because he felt it provided no benefit. Mick now tended to be more circumspect with others, but continued to look out for his friends. He admitted being unsure about whether he had dealt with the suicide but regardless, he now felt less constrained with his own behaviour:

Mick *I was actually shocked and I just wanted them to, try and forget like I was always with friends…I think I had offers to go to counselling. Dad took me to one and then he asked if I wanted to go again and I thought, I didn't see the point in it. I didn't get anything out of it. I don't know, I didn't have much emotions, after, a lot of people still think I haven't dealt with it, but I don't even know myself…little things don't matter to me anymore, like I just do, what I want to do. Like the way I cope with it, kinda now I don't try and let people too close. Like, if they start to get really close I'll kind of push them away a bit. Like I try and keep in contact with all my mates.*
[Peter, 14, 2yrs]

Zac, who was 14 years old when his close friend Dan died, explained he felt very distressed and lost. Zac's primary method of coping was to drink alcohol, mostly with a group of friends. Zac rationalised his drinking on the basis that this is what his friend Dan would have wanted. At the time, Zac said he would have refused any help or assistance as he was caught up in his grief. His experience of losing Dan meant he had become more reckless and less able to focus on the future. In total, Zac had lost two friends to suicide and he felt very pessimistic about some of his other friends (and perhaps himself) and their risk of dying by suicide:

Zac *Alcohol, I drunk twelve days straight... I would have turned it down. I was just in my own land of what the fuck do I do now…we do mad parties, and usually we got all smashed off our faces. Cause that's what Dan would have wanted. That's the way I see it now, because I lost someone so close, I see every day as my last day. So I live my life as like, a game I guess…I seen it as another one gone, it's only going to happen again. I know another one's coming, I seen, I'll see more of it in my life I know I will, I'll see probably more than that. Yeah, but I know I have friends who will do it. Cause I have friends that sometimes scare me, trip me out, I worry about them.*
[Dan, 19, 3mths; Vanessa, 19, 2wks]

When speaking of the strong drinking culture that continued after Dan's death, John did not see it as a way to forget or block out pain. John explained that Dan himself was a big drinker and partier so, in his friend's eyes, the continuing drinking was a celebration of Dan and a way of remembering him:

John *Drinking a fair bit, me and my mate and his brother. That, and he, the fellow himself, he was a real big drinker and he would always go out partying and we were just doing it in memory of him.*
[Dan, 19, 3mths]

Others, such as Amy, denied that they had used alcohol and other drugs. However, many of their friends used substances to help them cope with the death. For some friends, this became a regular method of coping, but had also led to other health and social problems that impacted negatively on their lives. This was not remembering, as John had suggested, but more firmly focused on escape and avoidance of memories of the friend who had died:

Amy *One of my friends in particular, she turned to alcohol and drugs. So every weekend it was, she would go out partying or she'd do drugs and try and, I think she was just trying to get away from the pain and the memories pretty much, and since then her life hasn't been very good. I know she had to move out of home because of her drug abuse and she has been in and out of shelters. Other friends nearly followed suit.*
[Rob 15, 22mths; Ruth, 21, 1yr]

Within Sue's friendship group, some friends started drinking alcohol. However, Sue said she did not think this was excessive and it was not used as a means to grieve the death of their friend:

Sue *Not really, like our kind of group wasn't, isn't really like that. Maybe some people might have started but not like excessive, or using it like a tool to get over it sort of thing*
[Carlos, 14, 2yrs]

While a number of the participants talked about alcohol, very few discussed the use of other drugs. Rachel was one of the few who mentioned both, and described this as a means of distraction from thinking about her friends (Neil, Bob and Chris) who had died:

Rachel *It was definitely because you don't, you don't think about anything, it just makes you want to have fun, you don't have time to think, like you know, drugs make you want to get up and go out and have fun so you're not sitting there, you're not thinking, it's not playing on your mind all the time.*
[Matilda, 14, 2 yrs; Neil, 17, 1 yr; Bob 20+, 1yr; Chris 20+, 1yr]

The participants commonly spoke of social withdrawal and isolating themselves more from others–any support sought was usually from their close friends and, in some instances, family.

Kate talked about how she withdrew from others because she did not think they could understand how she was feeling; she could not express the depth of her hurt and grief. She was also feeling suicidal. Despite feeling this way, Kate said that Louise's family were the ones who were directly affected and deserved support. In her view, the impact on her could not be compared to the size of their loss:

Kate *Well I sort of just withdrew partly because I didn't know who understood sort of thing, how I was feeling that sort of thing. A lot of people I associated with weren't directly affected by it so I sort of cut myself off from them, just not really associating much. I think I refused to acknowledge how, the extent of how I was feeling. Like I knew I was upset I knew I was hurt, but I didn't know then how much sort of thing…And as a result, afterwards I've experienced that somewhat so I know what she was going through. I didn't think that I could get to this point. I did not see me going past probably the age of fifteen, sixteen. Yeah, like this has directly affected them. This is their daughter, their sister, it's got nothing to do with me type of thing*
[Louise, 14, 8yrs]

Some participants had a changed perspective of suicide. Ben had experienced feeling down after the suicide death of Peter. Six years earlier, he had also experienced his own father's suicide and this had played on his mind. Despite this, Peter's death had brought Ben a new and positive perspective about opportunities

in life even amongst the sad recognition that someone so young could take his own life:

Ben *Yeah, probably like cause like I sort of went through some stages where, where not to the extent of suicide but, but sort of feeling really down and, I think it just sort of brought a new perspective that there is a lot better things out there and that, and how sad it is when someone so young, like takes that option.*
[Peter, 14, 2yrs]

Ben also saw how devastating the impact of suicide could be on family and close friends. For this reason, he considered others similarly exposed would definitely understand suicide was not an option for them if they were distressed. He admitted however that he could not realistically know what the views of other friends were on this matter:

Ben *Yes it gave me a better perspective on things, on how people react to such a thing, how devastating it is to not just your family but to a lot of people out there. Yeah I think that they would have, they would have definitely seen that if they were upset that it definitely is not an option to take, from what everyone else's reaction around them was. But, I don't know really what the perspective that they took on it was.*
[Peter, 14, 2yrs]

A small number of participants talked about their own impulsivity and potential risk-taking following exposure to the suicide death of their friend, which included thoughts of self-harm.

After Mac's death, Ed distanced himself from others; he was now more cautious about who he was and was not around. In the last twelve months, Ed had also felt depressed and tried to hang himself. He believed that knowledge about how Mac had died likely contributed to his choice of method, although his attempt was otherwise unrelated to the death. Ed was not aware of any other friends who were suicidal in the aftermath of Mac's death. In this case, Mac's closer friends were upset but not as visibly distressed as others, such as those who had bullied Mac:

Ed *I just didn't feel that I talked to people as much as I used to after it happened. I just kind of like distanced myself from the situation and talking to people... I pull closer to the ones that matter to me. Which back then was not many people I didn't really pull away from everyone, but I pulled away from the ones that I didn't want to be around… well I have been in that situation, with the whole depression and even attempted suicide, over the last year… with me trying to hang myself like he did. I suppose with his, with what happened to him kind of gave, brought up the idea that I could, do it the same way I suppose. No I didn't know of any people that came to that extent…I didn't see any distinct, well the main group of people sharing more emotion…I saw a few of his closest friends, sobbing lightly whereas some of the guys who were bullying him were completely bawling their eyes out.*
[Mac, 17, 2yrs]

Amy also talked about friends who had become distressed following Rob's suicide. Two of these friends had thoughts about suicide but had not disclosed these to anyone else. About three weeks after Rob's death, one rang Amy in the middle of the night because they were feeling suicidal:

Amy *Two of those have since had those sort of thoughts and have only*

ever told someone like myself or my sister and I get phone calls, I had one friend who about three weeks after Rob had killed himself, she called me up about two o'clock in the morning and said I am standing in my bedroom with a rope and I don't know why.
[Rob 15, 22mths; Ruth, 21, 1yr]

Most of the participants spoke of how they tended to disregard their own health, but were more focused on the immediate wellbeing of their close friends, and concerned about how those close friends were coping with the death. They established emotional connections, despite recognising their own withdrawal from others. Kate neglected herself but ensured her friends were okay:

Kate *I think I put a lot on how other people were dealing with it. Like I took into account how other people were feeling or might have been feeling, so I made sure that they were okay but as a result I neglected myself sort of thing.*
[Louise, 14, 8yrs]

For many participants, isolation was based on not wanting to trouble anyone. More specifically, they spoke about people who were more deserving of help and support, such as the family of the deceased. As friends, they did not want to detract from the family's need or access to resources that should have been available. Rachel and Lauren felt guilty about feeling distressed. They were not entitled to, and did not deserve, the right to access help regardless of how they felt:

Rachel *Like you know you don't want to take up people's precious time. Imagine being a mother of one of those people, I mean they need support more than I do. Whatever I was going through there was always a mother or a father, a brother, who had it so much worse*

about it, and that made me feel guilty, that I had the right to be hurt, like I didn't deserve that there was people out there that, that did have the right they needed the help. I wasn't going to take it from them.
[Matilda, 14, 2 yrs; Neil, 17, 1 yr; Bob 20+, 1yr; Chris 20+, 1yr]

Lauren *I was like I probably shouldn't worry about it too much, I should just make sure that the family is okay. And, cause I was just a friend, and it was just family and make sure that the family was okay first before I like sorted out myself.*
[Dan, 19, 3mths]

By denying her need for support, Rachel chose to keep things mostly to herself–she tried to manage independently because she believed this made her a stronger person. While Rachel eventually came to terms with Matilda's death, the cumulative experience of another three suicide deaths of friends became too much to handle:

Rachel *I kind of prefer to process things myself. I handle everything myself and it makes me a stronger person. I know that whatever life throws at me I can cope with it… I just could not handle it, like I don't know what I'd do if I had to go through it again, I don't think I could cope anymore.*
[Matilda, 14, 2yrs; Neil, 17, 1yr; Bob, 20+, 1yr; Chris, 20+, 1yr]

Sue also thought others were more deserving of support–people in general thought others were worse off than themselves:

Sue *I think it is, because, I think people feel sort of guilty about feeling sad about it because of you know like the whole third world country people are worse off than me sort of thing. Like I shouldn't be feeling it, so people like try and push away the feelings instead of*

like facing them.
[Carlos, 14, 2yrs]

Amber also felt that others were far worse off than her, including family and other friends:

Amber *Yeah I think I was, way more people are worse off than me kind of thing. Like not even related to Carlos but just like in general.*
[Carlos, 14, 2yrs]

Whilst a narrative of isolation existed, the participants shared a common view of a greater appreciation of life and the circumstances of others. They expressed being more aware of, and looking out for, how their close friends were managing after the death. This was consistent with their views about not being entitled to support themselves but ensuring others were okay.

Following her bereavement, Sue did not get close to people, unless she had concerns about someone, so they did not feel isolated. Due to her own experience of loss, Sue felt better able to read how her friends might be feeling and help them accordingly:

Sue *I don't, I think it has much like effect like that but I know that I don't get too close to people, but it's not the fact that like, I think I'll lose them. Like I think if I am going to lose them I'd get closer to them so they don't feel isolated themselves…like I can read people better sort of thing, I look out for more signs of like depression or anything like that more, and I feel a lot like, I feel a need to help people more because I know what it's like to be friends with*

someone like that, and the fact that I don't want anyone to go through that, like what I had or what anyone had to go through.
[Carlos, 14, 2yrs]

Similarly, Brad's experience of suicide had resulted in him being more motivated to actively seek out and support others:

Brad *When I hear of something like that happening I feel upset. It reminds me of what has happened, I'm sort of more on the ball when it comes to this. When someone's feeling sad I am more, oh I'll get to them, I'll come and cheer them up.*
[Carlos, 14, 2yrs]

Recognising distress following suicide was not always immediate. At the time of Mac's death, Ed struggled to see any positives but he had now learned from this experience and felt he could talk to others and assist them:

Ed *I'll just sit down and talk to them and say I have been in your, well not in your shoes but in the similar situation, and yeah is there I can help with, to make things a bit easier. I mean I'm just talking about views not the actual solution but there is a light at the end. I didn't think there was when I was in that situation.*
[Mac, 17, 2yrs]

In appreciating others more, Bron now felt better able to talk proactively to people, eliciting support if necessary:

Bron *I'm just more appreciative of the people that are in my life. So if anyone says they are feeling depressed or have been thinking about doing whatever, then I'm more like aware of that and the need to actually talk them to see how they are going and what's wrong and get them the help and what not. That, yeah just more appreciative of the people that are in my life.*

[Dirk, 18, 3yrs]

Dan's suicide had changed the way Lauren thought about the importance of life, and also how she responded to others and to their circumstances. She was now more likely to speak up in the face of criticism and presumption:

Lauren — *It's made me realise how important my life is, just made me think twice before I'd say if I'd let people go, this has made me think what's going on at home first. When people ask the other people who pick on other people, I'm like don't do that because you don't know what's going on in their life. It's changed me.*
[Dan, 19, 3mths]

The same suicide death can result in different experiences for bereaved participants. Whilst things had been difficult initially after Dan's death, John also now had a greater appreciation that other people were there to help and provide support if you did reach out to them:

John — *I was real sad at the start, but slowly starting to realise that people will be there for you if you need them to be and you actually show them that you need them there for you.*
[Dan, 19, 3mths]

Finally, Amber became much closer to her good friends and they, in turn, became closer as a group; shared concerns resulted in the proactive creation of safety nets among the friends. Amber felt that talking with her friends, or others who might have had similar experiences, was generally the best level of support she received. This was echoed by many of the participants.

Amber *I think I became like a lot closer with my friends who, his friends, who were all in that group. We all became a lot closer…I think just being with your friends and talking to your friends and maybe talking to other people who have been in that situation and how they felt with it, yeah.*
[Carlos, 14, 2yrs]

The majority of the participants were either close friends, or in the immediate friendship group, with the friend who died. In Locations A and C, there were four participants who were mutual friends and either close friends or part of the friendship group with the young person who died. The participants in Locations B and D were either close friends or part of the friendship group with the person who died, but those interviewed did not know each other. Irrespective of their location, 14 of the participants described their closeness to their friends following the experience of suicide. The rationale for this closeness was protective—to keep watch over each other, so that they would be safe. Zac's response demonstrates how friends viewed the importance of this closeness for their safety and care:

Zac *Dan introduced me to Cain, and we weren't the best of friends when we first met but, … and then when it happened, and I told him and he became friends with me really close, and if it wasn't for Cain, then I'd probably, probably wouldn't be here.*
[Dan, 19, 3mths; Vanessa, 19, 2wks]

Summary of qualitative results

The three key themes identified were largely consistent across the four study locations. The first theme—communication about the death—highlighted the role of social media, specifically Facebook, used extensively to convey information about the death, and readily shared by participants. However, this information often became distorted and developed into gossip and rumours that distressed close friends. Social media was also used by others to exaggerate closeness to the person who had died. There were also marked differences in how schools conveyed information about the death.

The second theme—response to the death—indicated schools were a major part of the local rural community for participants. There was no consistent response from schools. While some participants spoke positively of how their school responded, most participants felt dissatisfied. Schools either addressed the entire school body or focused on year or class groups. While most schools identified close friends as potentially at risk, there was a significant expectation that young people experiencing difficulties would self-initiate contact with services. Supports were generally offered for a short period (1-2 weeks) then withdrawn with a focus on getting things back to normal. Friends at other schools received little, if any support. The participants mostly ignored counsellors and family and, instead,

sought out support from their close friends. They also spoke of the silence and stigma that pervaded the local town, which prevented any discussion about suicide, including with the family of the friend who died.

The third theme was coping with the death. Reported alcohol use was high amongst many of the participants as was their tendency to isolate themselves. Many of the participants felt they did not deserve support because others were more important or deserving. At the same time, they became more focused on the wellbeing of their close friends. This shared concern helped create safety nets to support the wellbeing of their close friends. However, there was a particular disregard of their own health and wellbeing; the results of measures to identify this are presented next.

QUANTITATIVE RESULTS

The quantitative component of this research was conducted simultaneously with the qualitative core component for each participant. Standardised self-report measures were undertaken with each of the participants to enable comparison with population norms to understand the health and wellbeing of this suicide exposed cohort of young people. The measures used were chosen because of the relevance to the symptoms measured for people exposed to suicide and the availability of

population norms for young people in this applicable group. Two additional quantitative measures were included to gauge general health and alcohol use.

The quantitative results are presented in two ways. The first comprises results for each of the standardised measures with study participants' results pooled to enable comparison to population norms. Trends are then suggested for the total study participants on each of the standardised measures. The second consists of each participant and their scores on the standardised measures that were above (or below) significant cut-off points. This enables a description of each participant with a cumulative level of risk of potential symptoms across the various measures. For example, a participant who scored 20 or above on the BDI-II and above 50 on the CISS avoidance scale, would be considered to have two risk measures comprising a moderate severity of depression symptoms and greater use of avoidant coping in response to stressful experiences.

General health and alcohol use

Participants were asked to rate their general health on a Likert scale of 1 to 5 where: 1= *excellent*; 2 = *very good*; 3 = *good*; 4 = *fair*; and 5 = *poor*. They were then asked to rate their health now compared to 12 months ago, again on a Likert scale where: 1 = *much better than one year ago*; 2 = *somewhat better now than one year ago*; 3 = *about the*

same as one year ago; 4 = *somewhat worse than one year ago*; and, 5 = *much worse than one year ago*. The participants' average rating of their general health now was 3 (good); twelve months ago, their general health was rated at 2.61. Overall, the participants rated their general health as better now than it was 12 months ago.

Participants were asked how often they currently drank alcohol and to rate this on a Likert scale where: 1 = *never*; 2 = *monthly*; 3 = *2-4 times a month*; 4 = *2-3 times a week*; and, 5 = *4 or more times a week*. They were also asked how many alcoholic drinks they would typically consume on each occasion, as well as the type of alcoholic drink generally consumed (for example, spirits, beer, and wine). They were also asked the drink size (can or bottle), and whether it was self-mixed or pre-mixed, to determine the number of standard drinks. A Likert scale (determined by the author) was used for their responses to record standard drinks where: 1 = *1-2 drinks*; 2 = *3-4 drinks*; 3 = *5-6 drinks*; 4 = *7-9 drinks*; and, 5 = *10 + drinks*.

The twelve participants who reported consuming alcohol drank on average 2-4 times per month (mean = 2.83; s.d. = 0.72). Across all participants, the quantity of alcohol consumed on average was between 4 and 5 standard drinks (mean = 2.67; s.d. = 2.17). However, amongst the twelve participants who reported drinking alcohol, the average quantity of drinks consumed was between 7 and 9 standard

drinks (mean = 4; s.d. = 1.21). Six of the participants who reported drinking rated their quantity of alcohol consumed as a '5'; meaning they reported drinking in excess of 10 standard drinks each occasion they drank alcohol.

Summary results for health and alcohol use are displayed in Table 5.1. Graphs showing individual ratings can be found in Appendix 15.

General Health and Alcohol Use–Study Sample

	Mean	Median	SD
General Health (rated as good)	3	3	1.03
General health (somewhat better than 12 months ago)	2.61	3	1.15
Alcohol Use Frequency (all participants = about fortnightly)	2.22	2	1.06
Alcohol Use Frequency (those who drink = about weekly)	2.83	3	0.72
Alcohol Use Quantity (all participants = about four standard drinks)	2.67	3	2.17
Alcohol Use Quantity (those who drink = about eight standard drinks)	4.00	5	1.21

Table 5.1 General health and alcohol use

Self-report mental health and well-being measures

Means and standard deviations are shown for the study sample and the normative sample used for comparison. Also displayed are single sample *t*-test comparisons to respective normative scores for each measure. A per-comparison error rate of 0.05 was used for the analysis controlling the Type-II error rate at the level of the test only. No comparisons were made on the measures for differences by age, or by location, given the unequal numbers. Gender norms were compared where available.

CISS (Coping)

The CISS measures coping in stressful situations. Participant scores were divided by gender for the CISS scales of Task-Orientated Coping, Emotion–Orientated Coping, and Avoidance-Orientated Coping, as well as the two Avoidance-Orientated Coping sub-scales, Distraction and Social Diversion. All scores were within one standard deviation of the norm. Scores were in the average range for all scales except for females on Emotion-Orientated Coping, which was slightly above average, and for males on Avoidant-Orientated Coping, which was also slightly above average. Emotion-Orientated Coping appeared to be more prevalent amongst the female participants with the *t*-test falling just short of significance ($t(10) = 2.15$, $p = .057$). Participant males were less likely to use Task-Oriented Coping, but more

likely to use Emotion-Orientated Coping, Avoidance-Orientated Coping, Distraction, and Social Diversion, than the normative sample. Participant females were equally likely to use Task-Orientated Coping, and Social Diversion, as the normative sample. They were more likely to use Emotion-Orientated Coping, but less likely to use Avoidance-Orientated Coping, and Distraction, than the normative sample. These results are displayed in Table 5.2.

Self-Report Measures						
CISS	Normative Sample		**Study Sample**			
	Mean	SD	**Mean**	**SD**	*t(df)*	Sig.(2-Tailed)
Task						
Males	49.34	11.06	**44.71**	**7.83**	*t(6)* -1.564	.169
Females	49.56	10.55	**49.81**	**11.52**	*t(10)* .074	.942
Emotion						
Males	39.62	11.93	**45.71**	**10.39**	*t(6)* 1.552	.172
Females	48.38	11.27	**57.18**	**13.56**	*t(10)* 2.152	.057
Avoidance						
Males	44.91	10.98	**50.71**	**8.92**	*t(6)* 1.722	.136
Females	49.41	10.45	**47.55**	**8.73**	*t(10)* - .708	.495
Distraction						
Males	20.19	6.04	**22.42**	**6.99**	*t(6)* .847	.430
Females	21.96	6.40	**18.64**	**5.61**	*t(10)* -1.965	.078
Social Diversion						
Males	15.83	5.21	**17.71**	**4.68**	*t(6)* 1.065	.328
Females	18.14	4.71	**18.91**	**6.07**	*t(10)* .420	.683

Table 5.2 CISS coping skills

BDI-II (Depression)

The BDI-II total score mean for participants (mean = 20.11; s.d. = 12.86) was significantly higher than the comparison standardised norms (mean = 12.48; s.d. = 10.50) ($t(17) = 2.52$, $p = .022$). This score was within the moderate range of severity of depressive symptoms as specified in the revised BDI-II manual. Thirteen participants scored in the mild range (a score above 13), and four of these participants scored in the severe range (a score above 29). Overall, the participants rated a higher level of depression symptom severity compared to the normative sample. These results are displayed in Table 5.3.

Self-Report Measures						
BDI-II	Normative Sample		**Study Sample**			
	Mean	SD	**Mean**	**SD**	*t(df=17)*	Sig.(2-Tailed)
Depression	12.48	10.50	**20.11**	**12.86**	2.517	**.022**

Table 5.3 BDI-II depression symptoms

STAI (Anxiety)

Participants' scores were divided by gender for both state and trait anxiety scores on the STAI. All scores were within one standard deviation of the norm on this measure. However, the overall mean trait anxiety scores were elevated for both males and females. Thirteen of the participants recorded higher trait anxiety scores, and eleven participants recorded higher state anxiety scores, than the normative

sample. The mean trait score for females (mean = 50.00; s.d. = 10.81) was significantly higher than normative sample (mean = 40.97; s.d. = 10.63) ($t(10) = 2.77$, $p = .020$), and at the 80th percentile. This means the females in the study scored higher in trait anxiety than 80% of the normative sample. Both male and female participants were more likely to display trait anxiety symptoms than the normative sample. These results are displayed in Table 5.4.

Self-Report Measures							
STAI	Normative Sample		**Study Sample**				
	Mean	SD	**Mean**	**SD**	*t(df)*		Sig.(2-Tailed)
State							
Males	39.45	9.74	**40.43**	**7.30**	*t(6)*	.355	.735
Females	40.54	12.86	**41.00**	**10.93**	*t(10)*	.140	.892
Trait							
Males	40.17	10.53	**45.29**	**10.83**	*t(6)*	1.250	.258
Females	40.97	10.63	**50.00**	**10.81**	*t(10)*	2.769	**.020**

Table 5.4 STAI anxiety symptoms

PG-13 (Prolonged grief)

The average score for all participants on this scale (mean = 29.00; s.d. = 14.34) was equivalent to the population normative scores (mean = 28.57; s.d. = 12.66). Seven participants scored higher than the normative score, and four of these participants also met criteria for prolonged grief disorder. One participant did not meet the duration criteria as their friend's death had occurred less than 6 months ago. The

same four participants scored 50 or above on this measure, and at the 90th percentile, which is higher than 90% of the normative sample. Results are displayed in Table 5.5.

Self-Report Measures						
PG-13	Normative Sample		**Study Sample**			
	Mean	SD	**Mean**	**SD**	*t(df=17)*	Sig.(2-Tailed)
Grief post-loss	28.57	12.66	**29.00**	**14.34**	.127	.900

Table 5.5 PG-13 prolonged grief symptoms

SOSS (Stigma)

Stigma terms displayed in Table 5.6 are those that loaded most strongly for the factors of Stigma, Isolation/Depression, and Normalization/Glorification. Also included in Table 5.6 are the terms that were endorsed as significant compared to the normative sample. For the Stigma factor, the participants rated their responses to the items 'shallow', 'immoral', 'stupid', 'irresponsible', 'an embarrassment', 'cowardly', 'unfair', and 'unjustifiable' higher than standardised norms. Means were significantly different for the items 'immoral' ($t(17) = 3.40$; $p = .003$), 'unfair' ($t(17) = 2.94$; $p = .009$), and 'unjustifiable' ($t(17) = 3.41$; $p = .003$), meaning the participants were more likely to use and accept these stigmatising terms in relation to people who die by suicide.

Self-Report Measures						
SOSS	Normative Sample		**Study Sample**			
	Mean	SD	**Mean**	**SD**	*t(df=17)*	Sig.(2-Tailed)
Stigma						
Shallow*	2.20	.94	**2.44**	**1.04**	.996	.333
Pathetic*	2.00	.93	**1.61**	**1.04**	-1.591	.130
Immoral*	1.87	.89	**2.56**	**.86**	3.40	**.003**
Stupid*	2.25	1.06	**2.61**	**1.38**	1.112	.282
Irresponsible*	2.77	1.04	**2.78**	**1.17**	.028	.978
Embarrassment*	1.74	.93	**1.78**	**1.00**	.160	.875
Cowardly*	2.53	1.14	**2.67**	**1.08**	.535	.600
Vengeful*	2.21	.92	**2.06**	**.80**	-.817	.425
Unfair	2.71	.91	**3.39**	**.98**	2.943	**.009**
Unjustifiable	2.51	.94	**2.89**	**.47**	3.410	**.003**
Isolation/Depression						
Lonely*	4.19	.73	**4.06**	**.80**	-.711	.487
Isolated*	4.18	.73	**3.94**	**.80**	-1.246	.230
Lost*	4.20	.71	**4.22**	**.65**	.146	.886
Disconnected*	4.23	.72	**3.94**	**.87**	-1.388	.183
Alienated	4.05	.88	**3.56**	**.98**	-2.133	**.048**
Broken	3.91	.92	**4.28**	**.57**	2.716	**.015**
Glorification/Normalisation						
Strong*	2.22	.90	**2.72**	**1.18**	1.808	.088
Noble*	2.03	.81	**2.44**	**.98**	1.79	.092
Dedicated*	2.44	.83	**2.83**	**.92**	1.807	.089
Brave*	2.21	1.10	**2.61**	**1.29**	1.319	.205
Committed	2.62	.94	**3.00**	**.69**	2.350	**.031**
Total Stigma	162.93	n.a.	**166.39**	**19.02**	.772	.451
* Items with highest factor loadings (Batterham et al, 2013).						

Table 5.6 SOSS stigma items

While the participants rated items on the Isolation/Depression factor for 'lonely', 'isolated', 'disconnected', and 'alienated' less than the normative sample, the items 'lost' and 'broken' rated higher. Here, means were significantly higher for 'broken' ($t(17) = 2.72$; $p = .015$) and significantly lower for 'alienated' ($t(17) = -2.13$; $p = .048$).

These responses suggest that, overall participants were slightly less likely to have the view that suicide results from isolation and depression when compared to the normative sample. For the Glorification/Normalisation factor, participants rated the items 'strong', 'noble', 'dedicated', 'brave', and 'committed', higher than the normative sample. Here, 'committed' was rated significantly higher ($t(17) = 2.35$; $p = .031$). The results for this factor suggested that participants tended to consider suicide in more glorifying and normalising terms than the normative sample.

PTGI (Posttraumatic growth)

The participants' scores were totalled according to gender across the 21 items of the PTGI to determine a total mean PTGI score. The mean score for the female participants (mean = 63.81; s.d. = 17.09) ($t(10) = -5.13$; $p = .000$), and for the male participants (mean = 39.86; s.d. = 9.35) ($t(6) = -9.55$; $p = .000$), were significantly lower than the normative sample that comprised individuals who had experienced severe trauma. All of the participant's individual scores on this measure were lower than their respective gender normative sample mean. This means that participants did not report positive significant change in their life as a result of their experience of suicide. These results are displayed in Table 5.7.

Self-Report Measures							
PTGI	Normative Sample		**Study Sample**				
	Mean	SD	**Mean**	**SD**	*t(df)*		Sig.(2-Tailed)
Total PTGI							
Males	73.61	n.a	**39.86**	**9.35**	*t(6)*	-9.548	**.000**
Females	90.26	n.a	**63.81**	**17.09**	*t(10)*	-5.131	**.000**

(n.a.= not available)

Table 5.7 PTGI posttraumatic growth

Individual results

Results for each participant, and whether they rated above a clinical cut-off score on the standardised measures plus general health and alcohol use, are shown as health risks in Tables 5.8a and 5.8b. The participants are presented in the tables in the same order as they were introduced in Chapter 4 to reflect their respective geographic locations. Colours represent the participants from each location. The time since the death, the participant's age now and at the time of death, and the number of suicide deaths and other deaths experienced are shown. Also included is the friendship category of the participant with the friend who died (1= close friend; 2= friendship group; 3= friendship network). The last row of each table (total clinical risk) shows the cumulative number of ratings above clinical cut-offs for each participant with higher numbers indicating higher risk. The clinical cut-off scores for each measure were determined from the respective manuals and standardised norms. That is, where a participant was above clinical cut-off, they were scored '1'. These scores are

presented cumulatively. For example, a posttraumatic grief score below 50 means the individual is much less likely to experience or report a positive response to difficult life circumstances; and a depression score 20 or above equates to the experience of at least moderate depression symptom severity. A participant who rated below 50 for posttraumatic grief and above 20 for depression, would rate as '2' for total clinical risk. Scoring for general health status was selected as a rating of 4 or 5 (fair or poor), and alcohol consumption was selected as a rating of 3 or above (consumption of at least five standard drinks on each occasion of drinking alcohol).

Participant Name	Adam	Ben	Mick	Brad	Sue	Amber	Bron	Nadia	Amy
Time since death (mths)	24	24	24	24	24	24	36	12	12
Age now/age time of death	23/21	19/17	18/16	18/16	16/14	16/14	20/17	15/14	16/15
Suicide deaths – friends:family:other deaths	2:1:0	2:1:0	1:1:0	1:0:0	1:0:0	1:0:2	4:0:0	1 0 0	2:0:0
Coping Soc /Distract >25	Dis		Soc & Dis		Dis	Soc	Soc0	Soc	
Coping Avoidant >50			Avoid		Avoid	Avoid			
Coping Emotion >60					Emot			Emot	
Coping Task <40			Low task					Low task	
Stigma >165			Stigma	Stigma	Stigma	Stigma		Stigma	Stigma
Prolonged Grief >30					PG			PG	
Depression symptoms >20					Dep		Dep	Dep	
Post Trauma Growth <50	PTG	PTG	PTG	PTG					
Anxiety Trait-State >41	T & S	T & S			T	S	T & S	T & S	
Alcohol 5+ 7+ 10+	10+	7+	7+				5+		
Health Fair to poor							Poor		
Friendship Category	3	3	1	2	2	1	2	1	2
Gender	M	M	M	M	F	F	F	F	F
Location	A	A	A	A	A	A	A	B	B
Total clinical risk	4	3	7	2	7	4	5	7	1

Table 5.8a Participant health risks (Location A & B)

Participant Name	Zac	Lauren	John	Bronte	Belinda	Rache 1	Ed	Kate	Skye
Time since death (mths)	3	3	3	3	36	24	24	96	24
Age now/age time of death	14/14	15/14	15/15	16/16	17/14	16/14	19/17	22/14	17/15
Suicide deaths-friends:family:other deaths	2:0:0	1:0:0	1:0:0	1:1:0	1:0:3	4:0:0	1:0:0	1 0:0	3:0:0
Coping Soc/Distract >25		Soc	Dis				Soc	Soc & Dis	
Coping Avoidant >50	Avoid	Avoid	Avoid		Avoid			Avoid	
Coping Emotion >60	Emot	Emot			Emot	Emot		Emot	
Coping Task <40				low task	low task	low task			
Stigma >165	Stigma	Stigma						Stigma	
Prolonged Grief >30	PG			PG	PG	PG			
Depression symptoms >20	Dep		Dep		Dep	Dep	Dep		
Post Trauma Growth <50	low PTG		low PTG	low PTG					low PTG
Anxiety Trait-State >41	T & S	T	T & S	T & S	T & S	T & S	T & S		T
Alcohol 5+ 7+ 10+	10+	10+	10+		10+	10+		5+	
Health Fair to poor	Fair	Fair	Fair		Fair	Fair	Fair		
Friendship Category	1	1	1	1	1	1	1	1	2
Gender	M	F	M	F	F	F	M	F	F
Location	C	C	C	C	C	C	C	D	D
Total clinical risk	9	7	7	4	8	7	4	6	2

Table 5.8b Participant health risks (Location C & D)

Overall, the participants had experienced the suicide death of thirty friends, four family members, plus the death of five other friends. The results displayed in Tables 6.9a and 6.9b indicate that many of the participants carried a number of risk factors identified from the standard measures. Mick and Sue from Location A had scores in seven risk categories; Nadia from Location B had scores in seven risk categories; Zac, Lauren, John, Belinda, and Rachel from Location C had scores in seven or more risk categories; and Kate from Location D had scores in five risk categories. In general, these risks comprised several comorbid complications of

lower overall health, excessive alcohol use, anxiety, depression, and reduced coping skills. Eight participants rated depression symptoms at moderate levels or above, and also rated higher levels of anxiety. Further, four participants with depression symptoms consumed in excess of 10 standard drinks when drinking and rated their health as fair. Eight of the participants indicated they drank seven or more alcoholic drinks on each occasion they drank. Nine of the participants rated that they identified with more stigma-laden terms about people who died by suicide. Ten of the participants exhibited reduced coping skills; they were more emotional-focused and/or avoidant in their coping response. Eight of the participants did not experience posttraumatic growth following the trauma of their friend's suicide.

Summary of quantitative results

The supplementary quantitative results suggested that the participants generally reported their health as good, and slightly better than twelve months ago. Those who drank alcohol did so on average two to four times a month and would consume in excess of seven alcoholic drinks on the occasions they drank. Females were more emotionally reactive and males slightly more avoidant in their coping responses than population norms. The participants reported elevated depressive symptoms, increased prolonged grief symptoms, and increased anxiety. They also held slightly more stigmatising attitudes to suicide, were less likely to view suicide

as resulting from isolation and/or depression, and they also tended to normalise and glorify suicide. Finally, the participants were much less likely to experience some positive change, in the form of posttraumatic growth, following the experience of their friend dying by suicide. Individual summaries showed that most of the participants experienced a number of current psychological health complications.

SUMMARY OF RESULTS

The results described in this chapter comprise core qualitative themes that are supplemented by quantitative findings. The qualitative results comprised three main themes:

1) Communication about the death and how the participants were first told about their friend's suicide. Here, social media was implicated as a primary communication tool among participants, followed by information conveyed by their local school, and also rumours.
2) Response to the death and how school, family and friends, and the local community reacted to the suicide. Here, stigma, gatekeeping, and a reluctance to talk about suicide manifested in rural areas and, in turn, impacted participants help-seeking.

3) Coping with the death and how the participants and their friends managed their grief. Participants neglected their own self-care as they focused on the wellbeing of other friends, and, as such, implemented both helpful and not-so-helpful strategies.

The quantitative results demonstrated that participants experienced a number of negative physical and mental health concerns. These included high levels of alcohol use, high levels of depression symptoms, increased anxiety, an increased tendency to normalise and glorify suicide, reduced coping strategies, and less likelihood of positive growth following their friend's suicide.

The qualitative and quantitative results presented in this chapter are synthesised in the next chapter (Chapter 6) and discussed with respect to a number of key issues. These issues question the current focus on close friends at risk of suicide, and also the challenges for professionals and services about how they should respond to young people who lose a friend to suicide.

Chapter 6

Discussion

The previous chapter presented the results from the mixed-methods analysis of the experience of rural Australian young people who lose a friend to suicide. The data for the core qualitative analysis comprised the participant's interview transcripts and the supplementary quantitative data consisted of standardised self-report measures. A number of key issues arose from the results:

- communication about suicide and social media
- how schools respond to young people following suicide
- stigma and gatekeeping in rural areas
- psychological health and social risk factors following suicide
- suicide risk and friendship
- support for young people bereaved by the suicide of a friend

These issues are discussed in this chapter in relation to the existing literature, under three headings:

1. Communication—the role of social media with grief and young people, and the ways in which schools communicate with the student body.
2. Community context—the responses to participants following suicide, gate keeping and stigma, and the rural context in which these occur.

3. Continuum of risk—the rural specific individual adversity, and growth, demonstrated by participants.

Communication

For at least one of the participants (Kate), suicide was unknown until her friend had died. Once the word suicide had entered their lexicon, it became a possibility, and consequently a potential risk; as a result, appropriate communication about suicide is necessary. However, most participants chose forms of peer communication that do not necessarily allow for informed or appropriate discussion.

Social media

The most common discussion point in the narratives of participants concerned the social media platform (Facebook) and its role in communicating information about the death of their friend. Indeed, participants mostly learned about the death through Facebook. What followed then was often a flurry of communication as they attempted to ascertain what had occurred, who did and did not know, and how others were responding to the news. It appeared inevitable that participants become intent on sharing and communicating their feelings about the person who died. As a result, in these small communities, containing the spread of information about suicide was almost impossible.

This need to know and find out what had occurred expressed by the participants is well suited to the immediacy of social media. Nearly 93% of young people use the Internet to access social network sites (Burns et al., 2013), and about 95% own a mobile phone that they use to access Facebook and other social media sites (Australian Communications and Media Authority, 2013). Around 50% of young people sleep with their telephone turned on next to their bed, specifically so that they can respond to messages when these appear (Macpherson, 2013). The Internet, mobile phones and social media sites are very important aspects in the lives of young people. Robinson and colleagues (2014) examined the relationship between suicide and social media, and found that most people use social media to communicate about a death, meet others with similar problems, and to share their experience anonymously. This was the case for participants.

Facebook can provide a means of support in the time after the suicide death of a friend to share information and maintain connections between those bereaved (McKay, Tighe, & Maple, 2013). A deceased friend's Facebook page can also become a memorial site that can assist in the grieving process. Friends can continue to interact with the memorial page as they did with the active profile, so they can post condolences, share memories, and interact with past posts. However, for the majority of participants, it appeared that the Facebook page of the friend who had

died was not being managed or moderated in any active way following their death. As a consequence, the participants reported that posts made to their deceased friend's Facebook page did not assist the grieving process.

The Facebook Data Use Policy (2012) allows for others, such as family or a close friend, to notify Facebook when a user has died. Proof of death is required so that Facebook can switch the dead user's timeline to a memorial page, which can then be moderated by the initiator (usually a family member). A close family member can also petition Facebook to deactivate the deceased's account. However, without such action, the profile can remain open to all current activity and can also be hacked through someone gaining knowledge of the deceased's password. Determining how and where to find memorialising or deactivating information amongst the Facebook policy pages is difficult. The location of this information is not immediately clear, and Facebook has no search function to assist. Furthermore, anyone can create a Facebook page, whether a memorial or not, and in anyone's name, adding further confusion and hurt. In some cases, the parents or family of the friend who died may not even be aware of their son or daughter's Facebook identity or address. For parents and family who are experiencing their own grief and distress, contacting Facebook is unlikely to be a high priority, and may not even enter their current thinking at all. All the while, young people who were

connected in some way to the deceased will continue using this social media platform. For the participants, the Facebook posts became a media story, and they were involved from the minute they heard about the death. People who are bereaved by suicide do not find it helpful to be involved in a media story at the time of the initial trauma (Skehan, Maple, Fisher, & Sharrock, 2013).

Facebook pages are public, which means they are open and accessible to anybody who has approved friend status, although this can be broader to include friends-of-friends or, indeed, everyone (Facebook, 2013a). Young people are well-skilled in accumulating multiple friends using social media but friendship status does not necessarily reflect close friendship and young people can be indiscriminate with whom they grant friendship requests. This can be a concern as some friends who may not have known the deceased are able to make posts that might victimise the young person who died and harass their other friends. Cyber bullying, stalking, and other predatory behaviours delivered via online formats and through mobile devices means that young people can be targeted 24 hours a day because of most young people's engagement in virtual domains or communities (Burns et al., 2013). Studies have found that between 25% and 50% of young participants were being cyber-bullied (for example, Bhat, 2008), with bullying behaviour identified as exacerbating certain risk factors for suicide, such as isolation and conflict with

peers, which are contextual in youth suicide (Commission for Children and Young People and Child Guardian, 2012). Cyber bullying can also include offensive, vilifying, and stigmatising comments about the deceased and their suicide death and, in some instances, may also reflect a continuation of bullying behaviour (Luxton, June, & Fairall, 2012).

Even well-intentioned, but misguided, responses from posts over social media can cause distress to others. The participants frequently referred to others who spread rumours and gossip after their friend's death via Facebook, or said that others posted comments about how close they were to the deceased friend, when others knew this was not the case. In some cases, participants talked about disrespectful, stigmatising, and hostile posts—sometimes referred to as 'flaming' (Miller, 2009)—that were made about the deceased. Some of these posts were made by people who were known to the participants, but there were also others made by people unknown to them. These posts all added to the grief and confusion following the suicide and were not welcomed by the participants. Such posts are implicated in increased suicide ideation, and increased risk of suicide with vulnerable young people (Luxton et al., 2012).

Concerns about the influence, but also opportunities, of social media are being addressed. For example, Facebook has recently partnered with the USA Department of Veterans Affairs and the Durkheim Project (2013), to provide customised support for members of the military community at risk of depression and suicide. The project combines predictive analysis and search technology to estimate suicide risk based on what an individual posts to social media. Facebook has also teamed up with the Samaritans, a UK- and Ireland-based charity to launch a suicide alert reporting system (Samaritans, 2014). Facebook users can report individuals who they believe are expressing suicidal thoughts or intent, and users can also access help on their profile page. These suicide-related alerts are purported to be given top priority by Facebook's operation staff who then connect the person who reported the postings with the Samaritan team for guidance and support (Luxton et al., 2012).

It would be counterproductive to attempt to prevent young people from sharing their feelings about such a profound event as a friend's suicide death. Almost universally the participants spoke of Facebook as the primary means of being told about the suicide death. Facebook opened up communication—what had occurred and why—and this was considered important. In this situation, the participant's

own Facebook page, plus the use of other social media (such as Twitter, Tumblr) sustained an important connection amongst friends.

Schools

The participants said that after social media, the next most common mode of being told about their friend's suicide was by information provided by their school. Some participants reported that the entire school was told together, others said that individual classes or year groups were informed. In some cases, the police and the family of the friend who died had been asked to speak to deliver the news. There was also a difference in the amount of information the participants were told. When minimal information was provided, the participants said that invariably rumours and gossip abounded as people tried to make sense of what had occurred. This variation between schools belied any consistent approach, and supported the view in the literature that schools tend to respond to suicide in an ad hoc and inconsistent fashion (Doan, Lazear, Roggenbaum, & LeBlanc, 2012).

There is an expectation that schools will have policies and guidelines in place to respond to suicidal behaviour in the school community (Commonwealth of Australia, 2008). Despite increasing attempts to guide and operationalise how schools should respond following a student's suicide death (for example,

headspace, 2012), there is as yet no universal principle of how to respond, or what comprises evidence-based practice in this regard (Collings, 2012; Queensland Government, 2008; Szumilas & Kutcher, 2010).

A number of state guidelines for school postvention (for example, Department of Education and Early Childhood Development, 2013; Queensland Government, 2008; South Australia Department of Education and Children's Services, et al., 2010), generally articulate a hierarchy for informing students about a suicide. This hierarchy commences with friends closest to the student, then those in the same year level, students in the same class as a sibling, and then the school community. Some of the suicide deaths, discussed by the participants, had occurred prior to the issuing of the most recent school postvention guidelines. Notwithstanding this, participant responses suggested that most schools followed the hierarchy of advice that is generally contained across all the guidelines irrespective of year of issue.

As described in the previous chapter, some schools communicated differently about death by suicide than death from natural causes. It is important for schools to ensure their response to a student suicide death, and any other death, is consistent. Having a different approach for suicide can reinforce the stigma that surrounds suicide. It can also be deeply distressing for the family and friends of the student

who died (Doan, Lazear, et al., 2012). Schools also need to be careful about sanctioning any response that might in some way glamorise or normalise the student's suicide death. Participants reported that some schools over-exaggerated how good the student who died by suicide was; this largely had a negative impact on the participants. Such an approach can be problematic because it can influence other young people who might be susceptible to suicide risk by suggesting notoriety achieved by suicide, and can add to the risk of suicide contagion. It has already been described that participants rated Glorification/Normalisation items higher (on the SOSS) suggesting their vulnerability to this type of influence.

A student's suicide death presents complex challenges for schools. Responses from teachers and school counsellors provide important models for students, notwithstanding that these staff themselves face their own issues of grief and questions of guilt following a student's suicide (Parrish & Tunkle, 2005). Responses from a school that inadvertently makes suicide appear acceptable as a solution to problems can strongly influence vulnerable young people. Thus, it is important for schools to maintain care and consistency about the language used, their communication, and their response, to suicide.

Community Context

The increased propensity for exposure to the suicide death of a young peer in rural communities (Fullagar et al., 2007) means that many young Australians are likely to be subjected to stigma associated with suicide and its impact on social relationships, help-seeking, and community awareness (Suicide Prevention Australia, 2010a).

Stigma

There is often limited understanding of suicide in rural communities and, as such, personal attitudes are generally based on assumptions and myths that can translate into negative stereotypes of people who die by suicide as different to others (Clements, DeRanieri, Vigil, & Benasutti, 2004). The participants spoke about how suicide was hidden in their local community. They frequently used the word taboo when talking about suicide—others in the community were reluctant to discuss the subject, although some did admit that this probably reflected ignorance. Many of the participants said that they were more open to talking about suicide since their friend's death, which reflected a difference between generations. Many of the participants were critical about the lack of support offered by local services, including their own school.

The participant's narratives demonstrated an awareness of the need to change community responses—and these needed to be driven by young people themselves. One of the participants in Location B (Amy) had taken an active role to set up a Facebook page for youth support and suicide prevention and was prominent in working with the local media in relation to youth suicide. Despite awareness of the positive media response concerning suicide in Location D, stigma was still evident with one of the local high schools referred to as 'Suicide High' due to the number of suicides that had occurred there. One of the participants in Location D (Skye) said that this same school had also adopted different processes for responding to student death that unfortunately helped promote stigma amongst students.

Suicide, stigma, and mental health concerns are well documented in the literature (for example, Sudak, Maxim, & Carpenter, 2008). One of the common issues identified for people residing in small rural towns is limited anonymity. This can result in personal and health issues and concerns being hard to disguise or conceal. Rural communities can also promote stoicism, particularly among young rural males (Judd, Cooper, Fraser & Davis, 2006). This stoicism can result in difficulties admitting mental health concerns and then seeking support for fear of being seen as weak. The result can be a culture that dismisses help-seeking and fosters the view that people should just be able to get on with it and manage their illness or issue by

themselves. The stories of the participants highlighted each of these issues. They discussed being regularly confronted by others who wanted to talk indiscriminately about the death—the view being that they should be able to get over the death and move on. There was also the tough tradesmen image (mentioned by Adam) of some townspeople whose attitude was less accepting of mental health concerns.

The participants acknowledged that stigma was prevalent in their rural community. While they were more open to talking about suicide when reporting individually, stigma continued to stymie their conversations more generally. For example, some participants spoke of their reluctance to openly talk with the family of the friend who had died, and with other close friends at times, out of fear of what to say, and this reinforced the isolation experienced by families of those deceased. Others, such as Kate, spoke about their own isolation, which was perhaps related to an inability to know who to trust (Gilchrist & Sullivan, 2006a). Generally, the participants expressed a lack of willingness to engage with professional services for support. This may have been associated with their own sense of disenfranchised grief, and the failure of others to acknowledge their grieving and sense of loss; however, the participants also framed this unwillingness around their entitlement to, and expressions of, feelings of grief (Betz, 2006).

The quantitative analysis also suggested that the participants were more likely to use stigmatising terms, as well as glorifying and normalising terms, to describe someone who had died by suicide. Research has shown that the way communities socially construct thinking and understanding of youth suicide can prevent young people from discussing suicide and seeking help for possible mental health issues because they fear being seen as abnormal (Fullagar et al., 2007).

The participants spoke about the need for more discussion and openness about suicide and mental illness in their rural community. They felt that services and schools needed to provide more information and further follow-up for young people bereaved by suicide. The participants said that services and schools (counsellors) needed to have relevant experience about suicide so they could know what the bereaved person was feeling. The participants acknowledged that ultimately it was up to each individual to seek out support, but they also recognised how difficult it can be to talk about certain things—time, availability, and knowledge about services are necessary.

The views expressed by the participants make it appropriate to consider how to de-stigmatise mental illness, and particularly address the stigma that impacts those bereaved by a friend's suicide. There is current national debate in Australia, and

calls for submissions about public education campaigns (Australian Human Rights Commission, 2014) about how to raise awareness of suicide with young people. This is necessary to address the associated stigma, but without risking public discourse that might desensitise people to suicide, or heighten existing suicidal feelings.

Concerns have been raised that suicide awareness campaigns can risk making suicide appear normal or a reasonable response for others to adopt, particularly to young people (Gould, 1990; Sudak et al., 2008). There has been only limited research about positive behaviour change following suicide awareness campaigns (for example, Wright, McGorry, Harris, Jorm, & Pennell, 2006). Despite this, it is clear that young people discuss the subject of suicide among themselves, and they also hear about suicide from a range of sources that include media and gossip (Fullagar et al., 2007). Maintaining silence about suicide, because of fear of provoking suicide imitation, perpetuates stigma and dissuades young people from seeking support. It also limits appropriate adult perspectives and conversations on the subject of suicide that can challenge the (often) inappropriate views that young people might hear from peers (Fullagar et al., 2007). There is a need for proper consideration, critical discussion, and safe promotion of the problem of youth suicide in rural communities.

Much of the stigma about suicide, identified by the participants, related to their rural locations—comments such as small town syndrome and taboo. Judd and colleagues (2006) discuss that "important contextual and collective factors could be significant in explaining the elevated rates of suicide in certain rural areas" (p. 211). This raises the point that, if mental illness is not deemed to be appreciably higher in rural locations compared to urban ones, perhaps the higher suicide rate has something to do with rurality or the rural context. Judd and colleagues (2006) refer to specific characteristics (place effects) associated with rural towns, such as population decline and lack of infrastructure. These characteristics can have social, economic, and psychological impacts on residents that result in distress and less life satisfaction—all contributing factors to rural suicide. However, the low base-rate for youth suicide, as well as variability between locations and over time, can make it difficult to test the notion of place effects in relation to rural youth suicide. The study raised a number of examples of stigma that impacted the participants, and others, in their town about suicide, and the capacity to seek support.

Gatekeeping

The term gatekeeping was first coined by the German social psychologist, Kurt Lewin, in 1947 to explain the "focal points of social change in communities" (Barzilai-Nahon, 2008, p. 1493). This concept has subsequently become embedded

in many different fields, but essentially refers to the processes and decisions that are made about information, or goods or services, and when they can enter a system and at what point. In this study, gatekeeping occurred from a number of services and institutions in rural communities; consequently, possible participants were impeded from engaging in the study. The control of information from some services also impacted the availability and access to help for other vulnerable young people.

The reluctance of some service agencies to support and promote the suicide research study was described in Chapter 4. One particular agency (in Location B) was concerned that media promotion of the study, and interviewing young people who had lost a friend to suicide, would open the floodgates of people wanting support from the service. Health service management felt that the service would not be able to cope as their staff had recently been under considerable pressure due to previous suicides that had occurred in the town. In this instance, gatekeeping was being exercised out of fear of increasing new service referrals, despite the service agency having a key mental health support role in the town. The gatekeeping of this agency restricted young people's access to the study. It also reinforced silence about suicide and suicide bereavement with a presumption that, if suicide was not formally discussed, then there was no problem to be addressed. Gatekeeping from this agency in Location B also influenced other services in the town so

approximately 80% of identified potential participants did not, unfortunately, take part in the study.

Some of the schools in each of the four locations also exercised gatekeeping. There was a general reluctance to promote the research study by some schools, with this seemingly based on the fear of propagating distress in students. A school in Location C, which had initially agreed to promote the study, subsequently declined to be involved and directed its students not to participate in the research. Another school in Location A did not support its students attending a community forum about suicide postvention following the death of two young people in that location.

By presuming a negative impact, and subsequently censoring information for students exposed to suicide, schools effectively enforce a silence about the subject. This type of silence can particularly impact on whether young people feel they can openly talk to others if they have concerns about suicide. Such an approach can be a major disincentive to help-seeking (Stanley et al., 2009), which was expressed by many of the participants in their narratives.

Gatekeeping prevented young people from expressing interest in being involved in the study. More broadly, it also silenced young people, and others, about their

mental health concerns and about suicide. The participants spoke of their reluctance to talk to professionals following the suicide death of their friend. There is often a perceived lack of mental health specialist services in rural communities (Francis et al., 2006). Available services are often beleaguered by workforce shortages that, in turn, reduced the rate of service use (Kelly et al., 2010). If the available services promote silence about suicide out of fear of provoking distress or possible suicide imitation, then this further limits support, particularly for young people.

This can be further exacerbated if young people also experience mental health concerns. For example, Black and colleagues (2012) identify that rural young people with depression can have negative biases in their thinking, which can often extend to beliefs that services are either not available, or that they might have exclusionary waiting lists, which can reinforce decisions to not seek professional support. A number of the participants spoke about how suicide was generally not talked about in their town. In Location B, it was considered that mental health services were only directed at certain people and certain categories to the exclusion of others, which restricted access.

The participants rarely identified any support agencies that worked with their school following their friend's suicide death. Postvention guidelines identify that

other agencies, particularly mental health professionals, are "invaluable in assisting a school to manage its postvention responsibilities" (headspace, 2012, p. 11). However, the links between schools and mental health services are frequently inadequate (Collings, 2012). This suggests that schools and mental health support agencies need to work together and co-operate better in the aftermath of a student's suicide. Gatekeeping by either schools or services clearly impedes the postvention process and impacts help-seeking by bereaved rural young people.

The participants said that their schools tended to target closer friends and offered them different options, including open access to time outs, the capacity to visit a counsellor as required, and assignment extensions. The participants largely welcomed such responses, although others who were not deemed as close or attended different schools often missed out on any support from their school. The focus on close friends, which is consistent in current guidelines, has the potential to alienate other peers. This response points to an inequity and misunderstanding of the range of needs of young people who had been impacted by the suicide of their friend. This could be a possible reason why some peers exaggerated their friendship (as described by Ed and Skye), as it provided a means to be noticed and the potential opportunity to communicate their distress.

The implication of the greater focus on close friends following a peer's suicide death is that these close friends are at greater risk of suicide contagion and clusters (Commission for Children and Young People and Child Guardian, 2012). The South Australian Guidelines (South Australia Department of Education and Children's Services. et al., 2010) heavily inform other Australian State and Commonwealth school postvention guidelines. They make reference to the prevention of suicide clusters that involve not just young people who know one another, but also other young people far removed from or entirely unknown to the person who died and may identify with the behaviour. However, this broader consideration of peers was not made explicit in the other guidelines reviewed.

School screening

Given the age of the participants, school was an important location for support. All of the participants talked about their school's response to the death. For the most part, these comments were negative or neutral in nature. It is recommended in school guidelines that close friends be targeted for support after a student suicide (Collings, 2012; headspace, 2012; South Australia Department of Education and Children's Services., Catholic Education Office., & Association of Independent Schools., 2010). Other vulnerable students are mentioned in guidelines but it is not clear how schools identify who is vulnerable in these circumstances, with some

guidelines relying on staff to identify individual students who they feel are vulnerable or need support. The current approach has the potential to miss many students. A number of participants spoke of their school knowing little of their friend's suicide death or of their own distress. Additionally, teachers in rural locations may be reluctant to confront or identify students because of ethical boundary issues associated with being a teacher, being a local resident, and perhaps also a friend of the young person's family (Bourke, 2003)—they may also be bereaved themselves. Teachers may also lack confidence in their own ability to identify and follow-up young people at risk (Gould, Greenberg, Velting, & Shaffer, 2003; Martin, Richardson, Bergen, Roeger, & Allison, 2005).

None of the participants discussed whether screening of any form was undertaken at their school following the suicide death of their friend. They said that their school made decisions about who to target, based on staff's knowledge of students. Australian school postvention guidelines developed by headspace (2012) cite the need to identify vulnerable young people and provide some guidance such as looking out for changes in academic performance, changes in relationships and mood, and expressions of suicide and depression. Where screening was discussed, it was in the context of risk assessment undertaken by external agencies, such as mental health services; for example, "give the at risk person a referral to a mental

health professional for suicide risk screening" (headspace, 2012, p. 20). This assumes that suicide risk screening exists in (rural) mental health services that are often poorly staffed and not always accessible to young people (Australian Government, 2011).

The issue of screening is somewhat vexed due to concerns of possible iatrogenic risk (Gould et al., 2005), the lack of expertise within school settings for interpretation (Martin et al., 2005), and also limited research on its efficacy, with cost and time demands raised (Joe & Bryant, 2007). In USA school guidelines (American Foundation for Suicide Prevention and Suicide Prevention Resource Center, 2011), screening alone appears to have greater acceptance to identify those in the general student body who may be at heightened risk. However, secondary schools in the USA have been slow or resistant to implement screening for reasons including denial of the problem and time away from education and academic pursuits (Lieberman, Poland, & Cowan, 2006). There has been some controversy about screening in relation to parental consent and appropriateness of diagnosis, however Collings (2012) reports that one-third of the students identified by screening were not identified by other means, such as their teachers. However, whole of population screenings present challenges, given suicidality can vacillate within the individual, so schools would need to implement multiple screenings to

minimise false–negatives. Further, the success of screening must be dependent on the effectiveness of subsequent referral and uptake of services (Gould, Greenberg, et al., 2003).

The issue of screening to identify increased risk of suicidal behaviour has been investigated in Australia with a recommendation made to develop a simple screening tool by Martin and colleagues (2005). These authors concluded that a self-perception of failing was strongly associated with suicidality. Therefore, simply asking students about how they felt they were doing academically could inform decisions about more in-depth risk assessment. This could be combined with something more structured to maintain a parsimonious, but effective, approach to screening within the school setting.

While screening appears to have merit, and may identify those who are vulnerable, concerns were also reported, including that asking screening questions universally may be harmful or stigmatising (Gould et al., 2005). Nevertheless, Gould and colleagues (2005) found no evidence of any harmful effects from screening—in fact, "asking about suicidal ideation and behaviour may have been beneficial for students with depression symptoms or previous suicide attempts" (p.1641). This finding was also supported in an Australian study with a sample of adolescents in a

school setting (Robinson et al., 2011). Here, the authors combined a universal depression education program with an early detection program and found that the screened students were no more distressed than those who were not asked the screening questions. Furthermore, the screening identified a number of students considered to be at risk of psychological distress, self-harm, or suicide ideation that were not previously known to the school counsellor. These findings support a proactive approach to detecting risk in the school environment.

The body of evidence supporting screening, particularly in relation to the positive identification of potentially vulnerable students who would otherwise be missed, suggests that schools should implement a screening process for all peers following a student's suicide death. The aim of this screening is to determine whether more in-depth assessment is required. Studies have concluded that between 4% and 45% of students screened required further support (Robinson et al., 2013). Some of the participants remarked that participating in an interview, such as in the research, would have been a good option. Any such development would require rigorous research among diverse groups to fully understand the benefits and challenges.

School connectedness

School connectedness is a belief by students that adults and other peers in the school care not just about their learning, but about them as individuals (Centers for Disease Control and Prevention, 2009). The stories of the participants suggested a lack of understanding and consistency among some Australian schools to confront and deal with suicide, attempted suicide, and their impacts. In particular, gossip and rumours can proliferate when there is a lack of honesty about a student's suicide death (Suicide Prevention Australia, 2010b). In the study, schools appeared to contribute to this by their action and inaction following a student's suicide death. The gatekeeping response of some schools also contributed to stigma about suicide, which had the potential to further alienate students and reinforce their reluctance to seek professional help (Rickwood et al., 2007). While the reasons that contribute to the likelihood of a young person considering suicide lie mainly outside the school setting, schools provide a significant contextual setting for young people with the potential to moderate risk behaviour and identify young people at risk (Collings, 2012).

Access to counselling within schools varied across the sample. Some schools offered one-to-one counselling; others offered group options. The participants had different views about the appropriateness of these options, but were generally less likely to

use support groups, which is consistent with the literature (Parrish & Tunkle, 2005). Most participants either chose not to attend counselling or did so only for one or two sessions. The majority of the participants said they preferred to deal with the issues themselves or confide in their friends. Even those participants who engaged with counselling were sometimes equivocal, saying that counselling either appeared like a support group or the requirement to self-refer stopped them from attending. Others felt that the counselling provided was either too confronting or invalid because the counsellors themselves had no experience of suicide loss. This may also reflect that the participants were themselves unclear about their own needs in the circumstances and, hence, why support services should be more proactive in response to suicide.

Regardless of the counselling provided, most participants said that school-provided counselling was wound up in a short space of time with a back-to-normal approach enforced that left some of them floundering. The desirability of a quick return to normal routine was identified in several Australian postvention guidelines (headspace, 2012; South Australia Department of Education and Children's Services. et al., 2010). These guidelines advocated that schools should attempt to return to normal routine after approximately three days, on the basis that this facilitates recovery of all affected members of the school community. The return to

normal in a matter of days is not articulated as prescriptively in other guidelines, such as those from the USA (American Foundation for Suicide Prevention and Suicide Prevention Resource Center, 2011). These guidelines emphasise the need to maintain an environment focused on normal education activities and responses that allow students to return their focus to regular routines and activities, but no time periods are set.

Irrespective of the time for return to normal routine, some guidelines (such as, Department of Education and Early Childhood Development, 2013; headspace, 2012; South Australia Department of Education and Children's Services. et al., 2010) still discuss the need to maintain vigilance around student (and staff) wellbeing; this should continue for months, or longer as required. The stories of the participants highlighted that there were no consistent responses from the schools they attended, which was perhaps the goal in the absence of best practice. When schools returned to normal routine quickly, this was perceived by the participants as the school seemingly wanting everyone to just get over it and move on. Additionally, most participants spoke of interventions provided by schools that were only available for one or two weeks, with nothing more offered beyond this. When a death was unrelated to an individual school, participants were totally disregarded and had no support provided by their own school.

A possible reason for the negative feedback from the participants regarding the counselling received in their schools, and their own lack of engagement, might relate to there being no clear model about exactly what form counselling should take or what content should be included. This is partly because most of the postvention literature, dating back to the 1990s, is largely descriptive, and there are few robust studies that have measured efficacy (Collings, 2012). The quality of evidence for school-based suicide postvention programs has been described as ranging from very low (comprising case reports with limited critical appraisal), to moderate (including pre-/post-test with control group and limited follow-up); there have been no randomized controlled trials (Szumilas & Kutcher, 2010).

Support for rural young people

The participants highlighted many bereavement issues that they experienced, and had continued to experience, following the suicide of their friend. Many had either not sought support or were not identified within their school or community as requiring assistance. Many had rejected support offered by their school counsellor, even though some had commenced initial counselling sessions. For some participants, there was recognition that talking about their loss would have forced them to accept that their friend had died; at the time, they could not accept this, so they chose to avoid support. Many participants did not seem to have any sense of

how they might benefit from seeing a counsellor, which has implications for services. This indicates that young people bereaved by suicide need to know what seeing a counsellor means, and it is incumbent on services that provide bereavement support to make explicit what is on offer.

Notwithstanding the above, participants were very willing to talk about their experience in a non-counselling format with someone (for example, the author) willing to listen to them, even if this person did not have their exact same experience. This does appear somewhat contrary to statements from some of the participants who criticised counsellors because they did not have direct experience of suicide and bereavement. Breen (2007) talks about how being an outsider can sometimes encourage bereaved informants to talk about their experience, because the person is willing to listen and does not share aspects of their experience. The downside of this, particularly in rural areas, may be reluctance from local agencies to support an outsider and effectively block their actions and participation by gatekeeping (Breen, 2007). However, this reluctance could also stem from fear of the unknown, and perhaps the availability of funding. Consequently, a longer lead time could be spent unlocking some of these gates of misunderstanding.

Participants reported that the interview process was not distressing for them, despite some admitting this was what they had first anticipated. Consistent with other bereavement research (DeCou et al., 2013; Dyregrov, 2004), participants felt positive about their involvement in the research and appeared to find the process cathartic. They were the focus of interest and, for most, this was the first time they had been able to speak about their experience. The participants said it was important to get out what they were feeling, and they were hopeful that sharing their story would assist others. Some participants commented that the research interview provided a good model of what could be offered to young people who lose a friend to suicide.

The outcomes of the current study, and prior research into the needs of young people within the context of those bereaved by suicide and the ensuing grief, all point to further in-depth investigations (Balk, Walker, & Baker, 2010; Bell et al., 2012; Jordan, 2001). There is a dearth of research into the suicide bereavement experience of rural young people. There is also limited evaluation of intervention programs and activities (Andriessen & Krysinska, 2012; McDaid et al., 2008). Young friends are often missed in recommendations about suicide bereavement support, with the principal focus usually being on family members. For example, Jordan

(2001) indicated that bereavement services were directed towards family systems and "this seems particularly true for suicide survivors" (p.99).

The stories of the participants often pointed to a discrepancy between what they and others needed when a friend died by suicide, and what was provided. For example, most participants said they were required to initiate or self-refer to school support services following the suicide, but many did not self-refer due to reasons already discussed. Additionally, some schools and service agencies used gatekeeping to control referrals and this reduced the availability of services to provide support. There were often conflicts between the participants and service agencies, including schools, about youth suicide and the best ways to offer support. Service providers often believe that young people, friends, and family fail to recognise warning signs about suicide. Conversely, young people express they feel scared about what others might think, and that they might be judged by their peer and community networks if they access services (Gilchrist & Sullivan, 2006a). These comments support the need for greater awareness in the community about suicide and suicide risk, and that feelings of weakness or embarrassment for those seeking help need to be addressed.

Participants also spoke about the time-limited nature of interventions offered by their schools—most had continued to experience issues such as depression, alcohol use and anxiety since the suicide death of their friend. This suggests more intensive clinical follow-up is required, particularly those with pre-existing social risks. More than twenty years ago, Brent and colleagues (1993) described the mismatch between brief time-limited interventions, and the "needs of members of the social networks of suicide victims, who seem to frequently experience long, debilitating depressive disorders" (p. 516). The focus on youth suicide prevention in Australia, without consideration of postvention and bereavement issues, has perhaps allowed this to stagnate (Page et al., 2011). Schools and other services need to be able to offer interventions over a longer time-frame, perhaps up to three years following a young person's suicide death. This is consistent with recommendations from other recently published research (for example Swanson & Colman, 2013).

Many young people believe that suicidal people often lack someone they can trust and confide in. This has particular relevance for professionals, such as teachers and counsellors, because young people often voice that they are reluctant to attend or seek support from such professionals because of confidentiality concerns (Gilchrist & Sullivan, 2006a). It is, perhaps, for this reason that participants stated that they were more likely to confide in a peer than speak to an adult. It is important,

therefore, both within schools and the broader community, to improve mental health literacy so that peers feel better equipped to respond and assist their friends.

Continuum of Risk

The central aim of this study was to investigate the impact of youth suicide on young people in rural Australian because this group and their experiences have been largely devoid in the research literature. A key issue for consideration was the potential risk to participants resulting from their experience of the suicide of their friend. This is now discussed with respect to individual adversity and growth for the participants, which ranged from health and wellbeing through to the life-threatening end of the spectrum, suicide risk following exposure.

Adverse Outcomes

Quantitative analysis of responses given by the participants revealed they were at risk in relation to a number of issues including depression, anxiety, alcohol use, and prolonged grief. Some had been experiencing these issues for two and up to three years without previous detection. The participants were adept at masking their symptoms, or were perhaps in denial about them, and consequently did not communicate them to others. Regardless, they had not been detected in the school setting suggesting they had often slipped through any safety net being employed.

Different explanations for why young people appear more vulnerable than older people exist in the literature. The most plausible developmental argument to date is that young people identify more strongly with the actions of their peers, and a peer death resonates more strongly with young people than the death of an adult (Swanson & Colman, 2013). This is an age of development where there is increased vulnerability to mental health problems, and developing an entrenched mental illness can also increase suicide risk (Australian Bureau of Statistics, 2010b). Two of the participants (Ed and Bron) had been diagnosed with depression; one (Nadia) exhibited major symptoms of depression, and another (Zac) had been referred to a psychologist. It was not possible to determine whether some or all of these issues had only recently occurred, or whether they had stemmed from their experience of their friend's suicide, or whether they predated their friend's suicide. Depression and alcohol and drug misuse are issues that have been reported almost universally across studies investigating peer exposure to suicide (Cerel et al., 2005). Each will be explored below.

Depression

Depression has been strongly associated with suicidal behaviour, particularly for males with comorbid disorders (Hawton et al., 2013). The most significant issue for the participants seemed the likelihood of depression. This was consistent with other

studies involving adolescents and their response to the suicide of a peer (for example Feigelman & Gorman, 2008; Hoffman et al., 2010). Eight participants scored twenty or above (moderate depression) with four who scored above twenty-nine (severe depression). For these eight participants, the time since their friend had died by suicide ranged from between three months and three years. Four participants who scored in the severe depression symptom range on the BDI-II, also rated high on the prolonged grief scale (PG-13) with scores above the clinical cut-off of thirty-six (Prigerson, personal communication, April 21, 2012). It is likely that at least some of the participants' symptoms of depression were related directly to their bereavement and that these symptoms had been present since at least the time of their friend's death. These results are consistent with the research literature and the high comorbidity of depression and prolonged grief in young people exposed to suicide. Prolonged grief resulting from adolescent suicide exposure is reported as a strong predictor of depression for periods up to at least three years after the death (Brent, Perper, Moritz, Allman, Liotus, et al., 1993; Melhem et al., 2004b).

What is particularly concerning about the participants and their high rates of depression is that, for most, their own awareness and perhaps acceptance about their own mental health was low, or perhaps this has become normalised following exposure to suicide. This suggests low levels of mental health literacy—"[the]

ability to recognise mental health problems; knowledge and beliefs about risks, causes and effective treatments; and knowledge of how to seek mental health information and services" (Rickwood et al., 2007, p. S36). Young people can also fail to recognise distress that can result from depression (theirs and others), and their ability to access treatment and appropriate care is often limited (Boyd et al., 2006; Zachrisson, Rodje, & Mykletun, 2006). While this may have been a feature of the participants, the capacity of other adults to recognise distress in these young people also appeared limited. Low mental health literacy is not limited by age group (Jorm et al., 1997). Still, evident symptoms of depression, in some cases up to three years later, is consistent with the finding by Swanson and Coleman (2013) that "suicidal exposure still has some measurable effects 2 or more years later" (p. 6). Therefore, schools (and other services) need to be able to better identify young people who are experiencing symptoms of depression following a suicide, and interventions need to be offered for considerably longer periods of time than had been identified in this study.

Alcohol use

Alcohol use has been shown to be a major risk factor for suicidal behaviour in young people (Beautrais, 2000). Binge drinking is associated with suicide attempts (Hawton et al., 2012) and makes death by suicide more likely (Pompili et al., 2010;

Shaffer et al., 1996). A survey of drug use in Australia found that 22% of young people aged 17 years drank at a high-risk level (Australian Institute of Health and Welfare, 2005) and risky alcohol consumption among young people in Australia increased with remoteness. For example, Coomber and colleagues (2011) reported that 31% of young people living in remote Australia, aged between 16 and 24 years, engaged in risky drinking compared to 19% of their urban counterparts.

Alcohol use is commonly identified among suicide-bereaved individuals (Andriessen & Krysinska, 2012; Cerel et al., 2005; Hoffman et al., 2010). Twelve of the eighteen participants reported consuming alcohol at least fortnightly (and closer to weekly), drinking on average between seven and nine standard drinks on these occasions. Six participants reported drinking in excess of ten standard drinks on each occasion they drank alcohol. Some of the participants said that their deceased friend who had been a big drinker and partier influenced their high alcohol consumption. Others justified their drinking based on what they thought their deceased friend would have wanted. Whether an influence or excuse, the association between the friendship and bereavement can have a major impact on subsequent risk behaviours. Most of the participants indicated that their drinking commenced, or had considerably increased, since their friend's suicide death and that this was seen as a means of coping with grief and distress.

The quantity of alcohol consumed by the participants meant they were drinking at harmful levels (identified for adults over 18 years) with potential high risks to their health (Commonwealth Department of Health and Ageing, 2003). Smaller body size, less alcohol tolerance, and limited experience about the effect of alcohol added to this risk. Ten of the participants or 55% of the sample, drank alcohol at a risky or high-risk level, and were drinking at unsafe levels (Australian Institute of Health and Welfare, 2010), likely greater than the general population.

A number of the participants who drank large quantities of alcohol also rated their depression symptoms as high; three participants rated in the severe symptom range. This combination of alcohol and depression symptoms placed many of the participants at serious risk of harm through poor impulse control and risk for suicidal behaviours (Hawton et al., 2012). This can also be exacerbated by other comorbidities, such as anxiety symptoms (Patel et al., 2007), and potential for harm to brain development during the adolescent period (Toumbourou et al., 2007). Additionally, alcohol and substance use established in adolescence also predicts chronic patterns of morbidity and mortality in adulthood (Australian Institute of Health and Welfare, 2007b). This suggested that the participants were establishing a pattern of use that could be harmful in the longer term.

Social risk factors

Combined with high-risk alcohol use and comorbid psychological concerns, a number of participants had experienced a number of social risk factors. Six of these participants were from Location C (high youth population and low socio-demographics), and attended an alternative school for young people at risk of disengagement from the education system. These participants disclosed in their narratives that they had experienced disruptions in their family/living arrangements, as well as multiple school changes. Four of these participants experienced the recent suicide death of the same, slightly older, friend (Mac). Two others had experienced the suicide deaths of friends between one and three years ago. Rachel spoke clearly of how the death of her friend Matilda had severely impacted her coping; she had moved away from the rural town in which the death occurred. The subsequent deaths of three other friends in a short space of time "was just the icing on the cake" and led to enormous social disruption and distress, including a stay in a juvenile justice centre, before moving to Location C.

Previous research (Swanson & Colman, 2013) has reported a significant interaction between a previous stressful life event and the effect of suicide exposure. It was possible that the social factors experienced by these six participants exacerbated their responses to the suicide deaths of their friend. There were a number of risk

factors identified from the standardised measures for the six participants from Location C. Four of these participants described high levels of depression symptoms and all exhibited higher levels of anxiety. They also reported less task-focused coping, with more emotional and avoidant coping.

Research investigating young people's coping styles has suggested that avoidant or passive coping styles can mediate the development of depressive symptoms as well as behavioural problems (Gould, Velting, et al., 2004). Young people who are marginalised from their community are likely to reject prevailing community norms about acceptable attitudes and behaviours (Bourke, 2003). This can make them vulnerable because, when faced with a crisis, this non-conformity means there may be few adults capable, competent, or willing to provide assistance to the young person (Kölves et al., 2012). Young people who report poor social connectedness are more likely to experience depressive symptoms and psychological distress (Ottman, Dickson, & Wright, 2006). There is also evidence to suggest that people who come from socially disadvantaged backgrounds, like those from Location C, are more likely to engage in suicidal behaviours (Beautrais, 2000; Beautrais, Joyce, & Mulder, 1996). This potential concentration of suicidal behaviours means that young people who might be part of these groups are also more likely to be exposed to behaviours that increase their own suicide risk (Collings, 2012).

Families play a central role in young people's development and psychological wellbeing. Strongly connected communities and social networks are associated with positive outcomes for young people (Australian Institute of Health and Welfare, 2011). Conversely, suicidal behaviours can emerge in the context of longstanding family and childhood difficulties, disruptions and traumas (Briggs, 2002). The participants from Location C who identified social risk factors had disrupted connection with their family and community. They also displayed a number of significant health risks following exposure to their friend's suicide. Social risk factors need to be taken into consideration when identifying potential vulnerable students, as detailed in postvention guidelines (see headspace, 2012). These students are likely at increased risk for a range of mental health concerns and should be a priority for identification and support following a suicide death.

Friendship and risk

The issue of close friendship and suicide risk first appeared in the research literature over twenty years ago and this is inextricably linked to suicide imitation, contagion, and clusters. Despite some of the methodological and contextual issues regarding suicide contagion (Haw et al., 2013), a number of early studies investigating suicide and psychological risk for friends of young people who died by suicide did support a view that these friends may have had a pre-existing

vulnerability to suicidal behaviour. This was possibly a function of their assortative friendships and that subsequent exposure to suicide lowered the threshold for suicidal behaviour (Hazell & Lewin, 1993). These studies also speculated that amongst friends there seemed to be a difference of suicide risk that was seemingly mediated by the degree of closeness to the friend who had died.

For example, Brent and colleagues (1989) investigated suicide and suicide attempts in a high school following the death of two students. They found that close friends exhibited suicidality at a "lower psychopathological threshold than those who were less close to the victims" (p. 918). An Australian study by Hazell and Lewin (1993) investigated friends of young people who had attempted and/or died by suicide, and compared them to others with low exposure to suicide at two high schools. Their results suggested that young people who were exposed to those who attempted suicide displayed greater vulnerability to emotional problems, and possibly suicide. However, friends exposed to someone who died by suicide were less vulnerable compared with controls on dependent variables, including suicide ideation and current suicide behaviour (Hazel1 & Lewin, 1993). Brent and colleagues (1993) later investigated friends and acquaintances of adolescents who had died by suicide to determine their risk of depression, PTSD, and suicidal behaviour. They concluded that their results did not support that "the closer the

relationship to the victim and the greater the exposure to suicide, the greater the risk for imitative suicidal behaviour" (Brent et al., 1993, p. 516). While this early research suggested doubts about a close friend's vulnerability to risk of suicide, this view has shifted over the last twenty or so years such that close friends are targeted as those most at risk.

Research supports the idea that young people exposed to a peer's suicidal behaviour are more likely to have suicide ideation, suicide attempts, and engage in other risk behaviours (Cerel et al., 2005). However, the closeness of the relationship with the peer is not always made clear in these studies. Where this has been made more explicit, findings suggest that risks to young people exposed to peer suicide were greater for those more socially isolated from peers; denser social relationships perhaps increased peer-monitoring capacity (Bearman & Moody, 2004). Ho and colleagues (2000) made a contrasting finding: that a closer relationship had a higher risk for suicidal behaviour. However, this was mediated by exposure between suicide attempters and suicide completers, with peers of suicide completers having a greater risk of internalising problems. It was also acknowledged that the risk among peers was not evenly distributed.

The identification of risk to others more peripherally associated with the person who died, rather than closer friends, was also borne out in recent studies from the United Kingdom (Bell et al., 2012) and Canada (Swanson & Colman, 2013). The large Canadian study by Swanson and Colman (2013) provided evidence that young people who personally knew the deceased were not at increased risk for later suicidal behaviour but that "any exposure to a peer's suicide is relevant" (p. 878) regardless of the level of affiliation. The continuum of survivorship proposed by Cerel and colleagues (2014) provided some explanation of these differing relationships—the "attachment bond" (p. 6) of close friends perhaps mediated the immediate level of risk following suicide, but resulted in greater bereavement issues, such as prolonged grief, in the longer term.

The participants in this study were classified (by the author) into three different friendship groups based on their narratives that described the closeness of the relationship with the friend who had died:

Category 1—close friends of the deceased; eleven met this category;

Category 2—part of the friendship group of the deceased; five met this category;

Category 3—participants who were part of the broader friendship network; two met this category.

Category 1 friends were more likely to downplay their own entitlement for support—their needs did not compare to those of the family—but spoke of looking out more for their other close friends. Overall, the participants were considered to have a close relationship to the person who died and hence had greater exposure to their friend's suicide than other peers. The participants also had a high overall rate of exposure to suicide. They had collectively experienced the suicide death of thirty friends, plus four other suicide deaths of family members. Similar exposure to suicide has also been highlighted in the study by Bartik and colleagues (2013b), and other studies (for example, Swanson & Coleman, 2013), suggesting this is not a chance occurrence.

All the participants described responses, such as shock and disbelief, upon first hearing the news about their friend's death. Most acknowledged initially feeling down and distressed because of their loss. None of the participants talked about, or identified during the interview, that they had attempted suicide as a direct result of their exposure to their friend's suicide. One of the participants (Ed) described his suicidal behaviour, which occurred about twelve months after the death. However, his reasoning behind his own attempt was not related to his bereavement. One other friend (Kate) said her thoughts had become quite scary after her friend died and were manifested as diary entries that reflected suicidal ideation. Others

expressed fears about close friends and their potential for suicide. It is perhaps this fear of more deaths that results in the focus on the wellbeing of other friends, rather than being concerned about their own health and wellbeing. Regardless, most of the participants described appreciating and valuing their own life more since their loss. This was true of all friendship categories.

The participants also spoke about others, who they identified as not being close to the deceased, who were expressing considerable grief about the death and saying how close they were to the person who had died. The participants were particularly concerned about this exaggeration of friendship and distress by those they considered more peripherally associated with the young person who died. What was not clear was whether the participants viewed these others to be at greater risk of suicidal behaviours. Those peripherally associated with the person who died, appeared to be more alienated by their actions, such as expressing their grief (exaggerated or not) on Facebook. They were definitely exposed to the death, but they were not in the group of friends that received attention or support. They were also seen by participants to be more distressed by the death, and, as such, may be at greater risk of contagion of suicidal behaviour, because "they only witness the notoriety, hero-worship, and martyrdom associated with the suicide as it is often presented in the media" (Brent et al., 1993, p. 515). In the current study it could only

be speculated whether or not young people more peripherally connected to the young person who died were at greater risk of suicidal behaviour.

In any case, such expressions distressed many of the participants, and they identified different motives about these expressions. Some considered it an expression of guilt—these were attempts to apologise for behaviour towards the deceased, bullying being one example. Other participants felt disappointed and angry that these expressions were made after the friend's death, when they should have been offered to the person when they were alive. They felt that the motivation to do this was solely so that the person making the statements might be seen by others to be good. However, some participants were less concerned and thought it was nice that others were attempting to show they cared, even if they were not close to the deceased.

One participant (Skye) offered an explanation as to why more peripheral associates exaggerated their closeness and distress. She described herself being less distressed over someone she knew well who had died, because she would always have memories of her time with that better friend, whereas with someone she did not know as well, she was upset because she would never have the chance to know them and have such memories. This suggests grieving for the loss of idealisations;

those things that sustain self-image "for what we have done and what we have not done" (Raphael, 2005, p. 40). Exaggerated closeness has been identified as a possible response following other traumatic death and distress (Hughes et al., 2011; Pynoos & Nader, 1989), and may relate to the shared traumatic experience increasing the perceived closeness to someone who has died. However, this group has not been considered closely within the suicide research literature.

The participants almost universally identified that they now were more vigilant about their other close friends following the suicide. This was expressed by close friends (Category 1) and those in the friendship group (Category 2), suggesting this view was mediated by relationship closeness. They said they had become closer to these friends and they described being able to better read people, understand the impact of someone's home situation and how this could influence behaviour, and hence, look out for issues such as depression. In general, they felt better able to actively support their good friends, reflecting how important peer groups were for support following suicide, as previously reported (Bartik et al., 2013a; Bearman & Moody, 2004). This preference of friends over professional support has also been found in other suicide postvention studies (Trimble, Hannigan, & Gaffney, 2012).

Principally, the participants identified that their experience of their friend dying by suicide had brought home to them the impact of this event, not only on themselves, but also their close friends, and the deceased friend's family. Nearly all the participants said that the priority for support needed to be the family of the young person who died. They identified that the family's experience of suicide was far worse than their own and hence they did not feel they deserved support—certainly not at the expense of the family. They spoke of becoming more isolated, but at the same time, looking after their own close friends and that they were more aware of, and felt better able to detect, when their good friends might be feeling down or depressed and needing support. Whilst this greater monitoring has an important function of peer support (Bearman & Moody, 2004), the participants were less inclined to seek out professional services for support. This had implications for their own health and also that of their friends. However, a number did find support of some kind. Some found external support helpful; others preferred peer support, and taking on responsibility for peers. This shared experience within a friendship group and community gave the participants language to engage with others they were concerned about.

The distress resulting from their friend's suicide was perhaps one of the reasons participants said they now better appreciated their own life, and perhaps why they

had mostly not placed themselves at risk of suicide or suicidal behaviour. This type of acknowledgement is more in accord with earlier studies whereby it was argued that closer friends were inhibited from engaging in suicidal behaviour because of their exposure to "the painful after-effects of the suicide on friends and family" (Brent, Perper, Moritz, Allman, Schweers, et al., 1993, p. 515).

The current study suggests that close friends of young people who die by suicide in rural Australia are not at any greater risk of developing suicidal behaviours than other exposed peers. As such, school postvention guidelines that focus on close friends as a priority for suicide contagion, although well-intentioned, are likely to miss the mark. The research evidence points to the fact that postvention activities need to target all students bereaved by suicide, irrespective of their level of friendship with the person who died, as it appears that any exposure to a peer's suicide may be relevant. For the participants, following the death/s of their friend/s, there was considerable risk for the development of mental health issues.

In general, young people consider the topic of health a low priority (World Health Organisation, 2003). A lack of consideration of mental health as a primary component of overall health has also been associated in some studies with self–stigma (Francis et al., 2006). A young person can self-stigmatise for having a mental

health problem and then be less likely to seek support because this is seen as a sign of weakness. Young people may be concerned about being seen as 'mental' (Rickwood et al., 2007), and this type of stigma also reduces or prevents help-seeking. The negative association between help-seeking and suicidality has been well established (Klimes-Dougan, Klingbeil, & Meller, 2013).

While participants expressed new concern for the wellbeing of their closest friends following the death/s, it belied recognition of their own health issues and the tendency to isolate themselves from others. It also questioned their capacity to take on the responsibility of helping friends with potentially complex problems (Carr-Gregg, 2003), with elevated grief a feature. Treatment interventions for mental health issues such as depression, for which there is a strong evidence base, are generally perceived less favourably by young people (Jorm & Wright, 2007). Social support seemed to be the focus for the participants in assisting their friends. Most spoke about denying or disregarding more formal offers of counselling support at the time and since.

Notwithstanding issues of access, availability, and appropriateness of youth mental health services in rural areas (Boyd et al., 2007), the lack of appropriate referral and mental health care potentially placed a number of participants at risk. This

appeared to come about because of a general ignorance (in both adults and participants) of mental health issues. Greater mental health literacy can increase public knowledge and improve the capacity of those within a young person's social network, including close friends and family, to support access to appropriate assistance.

Summary

This chapter has elaborated on issues that arose from the qualitative analysis of the participants' transcripts and their results on the quantitative standardised measures. Communication about a friend's suicide death has major implications for the use of social media, with Facebook the predominant choice for participants. While there are many benefits of communication via Facebook, there are also many concerns that highlight the need for rapid moderation of the deceased's Facebook page to curb inappropriate use. These learnings are also relevant to other social media used by young people. The response from the participants' schools was also quite varied and added to the stigma experienced. The community context further exacerbated concerns for participants with regard to stigma and gatekeeping. Despite guidelines that recommended the need to identify young people who may be vulnerable following exposure to suicide, the rural community context generally denied participants appropriate access to support. The result for many participants

was a continuum of risk from individual adversity of mental health concerns through to risk of suicide, with consideration of close friends and others more peripherally associated with the deceased friend. Recommendations about these issues are made in the concluding chapter (Chapter 7).

Chapter 7

CONCLUSION AND RECOMMENDATIONS

Introduction

Suicide is the leading cause of death of young people in Australia. This outcome is all the more tragic considering young people should be experiencing peak health and laying the foundations for a happy, productive and successful future. Instead, a young life lost has major adverse effects on family, friends and the community. More broadly, this early loss of life has major economic costs for Australia.

In Australia, the primary focus for youth suicide prevention has been the amelioration of risk factors to reduce the number of young people who die. While it is critical to focus on youth suicide prevention, it is inevitable that suicide death will continue to occur. This means that attention also needs to be focused on the significant population of those bereaved by suicide who are themselves at risk of suicidal behaviour and associated health complications. However, the needs of people bereaved by suicide are still not well understood. Specifically, the needs of young people who lose a friend to suicide have received scant research attention. Rural young people who lose a friend to suicide, and who continue to reside in

their rural location, have not been the focus of any research. Their experiences are missing amongst those bereaved who have previously informed the literature. The present research aimed to address this issue, and in doing so, broaden the knowledge base of those bereaved by suicide.

This study used a mixed-methodology to investigate the experience of rural young people who lose a friend to suicide. The participants were able to talk about their relationship with the friend who died, and the response from other friends, family, schools, and the local rural community. Quantitative measures assessed aspects of mental health as a consequence of the bereavement experience. The guiding research questions were:

1) *How do rural young people live through and with the suicide death of a friend?*
2) *Are there adverse and/or positive outcomes associated with being exposed to a friend's suicide death?*
3) *Do young people have suggestions for ways in which they need support following this event?*

Eighteen participants from four different rural Australian locations completed individual in-depth interviews and standardised questionnaires to meet the aims of the research. The worlds of the participants and the interview circumstances were

explored in Chapter 4. The results of the analysis of participants' narratives and the standardised measures were presented in Chapter 5. The synthesis of these results was discussed in Chapter 6. The research findings comprised three key themes:

1) How the participants communicated about the suicide death of their friend
2) How the participants and the local community responded to the death
3) How the participants coped after the death and the impact that the suicide had on them.

The first theme highlighted the role of social media, and specifically Facebook, as an important communication tool used by participants. Facebook facilitated the rapid sharing of information about their friend's death, but it also became a major source of distress. Others who were not close to the deceased made inappropriate posts, often consisting of negative or derogatory comments about the deceased, and this created tension and distress among friends. It was also common for others, usually those who did not know the deceased well, if at all, to exaggerate their closeness to the person who had died. There was generally no moderation of the deceased's Facebook account and this resulted in negative comments continuing to be made about the deceased on their Facebook page, which was then automatically shared with friends and others. Gossip and rumours about the death were also common in rural communities.

The second theme comprised the local community's response to the death. Most of the participants were attending school, and most were at the same school as the friend who had died. As such, schools had a major role in responding to the suicide death and facilitating support. There was considerable variation in the response from schools and particularly how news of the death was explained to students. Some schools targeted small groups, others whole school assemblies. Some schools invited family members and police to talk to students. Some participants said that their school actively denied acknowledging the suicide. Some participants identified that their school discriminated in their response to students who had died by suicide, compared to students who died from other causes. Schools mostly targeted students that they (the school) identified as being close friends with the person who died. Presumably this was due to concerns of suicide contagion and the potential risk of imitative suicidal behaviour.

While counselling was offered at most schools, this was often time-limited and required the students to self-refer, and most did not. Participants identified that they were reluctant to see counsellors, but they were also reluctant to speak with their own families. Instead, they preferred to seek support from their own close friends and reported that they would closely monitor each other. This focus on

someone else often resulted in denial of their own needs, and most of the participants stated they did not feel entitled to seek support for their grief. In addition, the potential of suicide risk for peers who were less close and had less social support was also raised by the participants. They also spoke of fear and stigma about suicide that was prevalent in their rural communities. This stigma polarised the availability and provision of support for young people at risk of suicide.

The third theme consisted of how the participants coped with the suicide death of their friend. Most became isolated and disregarded their own health, and some friends became quite impulsive and reckless with their behaviour. Most friends spoke of being vigilant about their own close friends who were also bereaved by the suicide. They were acutely aware of the impact of suicide on others, such as the immediate family, and they responded with intensive peer-monitoring to keep each other safe. However, their own coping skills were compromised. While most of the participants rated their current health as generally better than 12 months ago, they had high levels of problem alcohol use. They also displayed significant depression symptoms as well as prolonged grief and anxiety symptoms. For many participants, these symptoms were still present two and in some cases three years after the

suicide death of their friend. These findings support the need for intensive and longer follow-up for rural young people bereaved by suicide.

Contribution of the research

Bereavement experience of rural young people

There are very few published studies that explore the experience of rural young people who lose a friend to suicide, even though this experience is critical to help inform interventions. Jordan and colleagues (2011) describe that most mental health interventions are created top-down by well-meaning clinicians and researchers. Bottom-up approaches that are based on listening to and exploring the needs and experiences of people bereaved by suicide, and engaging them as active research partners, should be the first step in establishing effective services (Andriessen & Krysinska, 2012). The findings of this research will assist in informing such bottom-up approaches by providing first hand experiences of those bereaved to a broader audience.

Ethical considerations are likely to contribute to the lack of research with young people. Disenfranchised grief and the conspiracy of silence that often surrounds suicide further deters research participation (Bell et al., 2012). Ethical considerations are usually based on concerns that discussion of suicide can heighten suicide risk,

despite evidence that participation in bereavement research is often positive and therapeutic, and that participation does not cause harm (Biddle et al., 2013; Chapple & Ziebland, 2011; Hawton, Houston, Malmbergand, & Simkin, 2003). Inviting and engaging young people to participate in bereavement research helps to redress the wider societal stigma and reluctance to talk about suicide. It also acknowledges the rights and dignity of young people to have an active contribution to research that is used to assist them.

Who is at risk of adverse outcomes?

Research over the last twenty years has indicated that close friends of young people who die by suicide are at increased risk of suicide contagion and subsequent suicidal behaviour. This is despite the limited capacity of these studies to actually gauge the closeness of relationships. One consequence is that school postvention guidelines focus on close friends as the priority for intervention following student suicide. The current study questioned this assumption and suggested that peers, even those peripherally connected to the deceased, are more likely to be at greater risk of suicidal behaviour and, as such, require greater consideration.

The participants—the majority of whom were close friends with the person who died—identified that they were openly exposed to the impact of the suicide on

immediate family, and also each other. Because of this, they closely monitored their other close friends to keep them safe. Peripheral friends, and those who exaggerated their friendship with the deceased, are removed from this immediate protective effect and are likely excluded from formal supports because they are overlooked when schools consider who is vulnerable following a suicide. However, they are exposed to the notoriety surrounding the suicide. In this way, they are at increased risk of imitative suicidal behaviour. Such a finding is consistent with studies over twenty years ago (for example, Brent, Perper, Moritz, Allman, Schweers, et al., 1993), and also more recent published research that suggested that any level of affiliation with the person who died is relevant for consideration of suicide risk (Swanson & Colman, 2013). As described by Kowalenko and colleagues (2013), a vulnerable adolescent, in a vulnerable group, with a vulnerable relationship with parents, and without an alternate source of containment, is vulnerable in the context of a significant stressor.

The participants did not display suicide risk but they demonstrated a range of health issues that included depression, anxiety, poor coping skills, and problem alcohol use. These issues were even more pronounced for those participants with pre-existing social and family disadvantage. However, these risks were not recognised by the participants, nor were they detected by those in their immediate

support networks such as their friends or professionals at school. This speaks to the capacity and awareness of school welfare support staff to see beyond suicide risk, and identify other potential risks in young people bereaved by suicide. It also questions the mental health literacy of young people, and their capacity and competence to identify concerns and know what to do about these concerns. Health issues such as depression, anxiety, and problem alcohol use can be quite debilitating for young people. Barriers to accessing care and support can be structural, with some young people reliant on their own resources to get help when they may not have the emotional or financial capacity (Arnett, 2007; Yap, Reavley, & Jorm, 2013), and other young people resistant to seek help due to embarrassment or fear of negative judgement (Jorm, Wright, & Morgan, 2007).

Contribution to practice

How young people experience professional services can influence their future help-seeking behaviour (Manganello, 2008). Resistance, or a poor response from a service, has the potential to alter the likelihood that a young person may seek assistance in the future, and this was demonstrated in the current study. The majority of the participants were reluctant to engage with professional counsellors despite their obvious distress and subsequent health issues. While this might indicate limited availability of services in rural Australia, it also suggested that

many participants lacked knowledge about counselling services and how counselling could assist them. Services need to better promote themselves, and also address the fear or stigma that might be associated with attending counselling. The manner in which the participants engaged with the bereavement research interview suggested that initial contact for young people bereaved by suicide should not be counselling-focused, at least in the first instance. Participants stated they were not ready for counselling immediately after their friend's death, but were more receptive to the idea at a later time. A supportive meeting, such as the research interview, could provide a starting point to assist young people immediately after the suicide, and help them select the best manner of support. Being able to tell their story when first bereaved, without an agenda, and with someone who is there to listen and not tell them what to do, is more than enough to try and work out how to articulate their grief.

The study also demonstrated limited awareness of postvention programs in Australia suitable for bereaved young people. Key government suicide prevention policy documents (such as NSW Department of Health, 2010) do not include postvention in their strategic directions. This type of omission disregards what can be done to support young people bereaved by suicide. It also fails to provide support for research and the development of evidence-based responses. The result

is an assumption that suicide bereavement is a homogenous outcome with the differing needs of bereaved young people ignored.

The suicide bereavement needs of young people are not the same as adults. Without research and input from young people, there is the likelihood that interventions will be based solely on adult perspectives. For example, support groups are often advocated to assist people bereaved by suicide on the basis they support reflection of coping strategies, and can challenge stigma and shame associated with suicide. However, evidence for the effectiveness of interventions such as support groups is "thin on the ground" (Bell et al., 2012, p. 62). In fact, little is known about the effects of providing support and the available research evidence is clouded by methodological issues that limit practice implications (Gaynes et al., 2004; McDaid et al., 2008). The participants were not in favour of support groups or group sessions with their peers. This suggested the need for more considered interventions that were suitable for young people bereaved by suicide.

There is limited evidence to inform best-practice postvention procedures in schools, and recently developed Australian school postvention guidelines have not been evaluated. Despite this, the Australian national youth mental health foundation, headspace, commenced what they referred to as an evidence-based secondary

school suicide support service in 2012 (headspace, 2013). The reference to an evidence-base, refers to the headspace school postvention guidelines (headspace, 2012). Irrespective of the legitimacy of this claim, the current study contributed to practice by providing research evidence to inform and improve guidelines targeting vulnerable students—the need for longer term interventions and the impact of social media.

Recommendations from the research

The findings from this research study support a number of recommendations. These include how to identify vulnerable young people in schools following a suicide death, and postvention practices that could be implemented. Other recommendations focus on the social media platform Facebook, but could be equally applied to new social media platforms increasingly embraced by young people. Finally, recommendations are made with respect to improved mental health literacy within rural communities.

School responses: Vulnerable students and screening

A school's attempt to determine vulnerable students following a suicide was generally deficient and often missed participants who were bereaved. Recent Australian guidelines (for example, headspace, 2012) highlight that schools should

work alongside mental health professionals to identify those students who are vulnerable and at risk. However, rural areas do not always have mental health professionals readily available to assist in this regard; in some locations, agency gatekeeping can actively prevent this access and referral.

The study supported that participants who were already experiencing social risk factors were more likely to be distressed, particularly so if they knew the student who died. Close friends will also be distressed, but their level of risk is less related to suicide contagion and more likely to manifest in a range of other risk behaviours that will require assessment, intervention, and support over time. More peripheral peers appeared to be at risk of suicide contagion. Their greater social isolation meant that they were often missed when schools were considering who required support. Irrespective of the availability of a mental health professional, schools need to consider implementing a screening process following a student suicide to determine who is potentially at risk and who requires more proactive follow-up.

Screening questionnaires are used in American schools as a whole of school primary suicide prevention approach (Hallfors et al., 2006; Robinson et al., 2011). Two examples are: *TeenScreen Schools and Communities* (TeenScreen); and, *Signs of Suicide* (SOS) (Substance Abuse and Mental Health Services Administration, 2012).

TeenScreen consists of a short screening questionnaire for grades 6-12 where those at risk meet with a mental health professional. Those not at risk have a de-briefing interview. In the USA, TeenScreen requires active parental consent. The SOS is curriculum-based and consists of 1–3 lessons accompanied by screening. Those at risk are given an assessment interview. Other components comprise staff in-service and a parent education night. In the USA, parental consent for the SOS depends on school district policy, which varies between active, passive, or no consent (Substance Abuse and Mental Health Services Administration, 2012).

Screening can be costly, time consuming and result in false positives, but does have some support because of success in identifying young people at risk of suicidal behaviour (Cox et al., 2012; Gould, Greenberg, et al., 2003). As an alternative, Martin and colleagues (2005) advocated that a simple question about perceived academic performance—"how do you think you are doing academically" (p. 85)—was able to screen and predict suicidal thoughts and behaviour of adolescents. This finding determined the need for in-depth clinical assessment.

Asking adolescents about suicide does not increase the risk of suicidality (Hawton et al., 2012). Studies determining the efficacy of screening programs suggested that young people answer honestly if they are suicidal (Doan, Roggenbaum, Lazear, &

LeBlanc, 2012). On this basis, it seems appropriate for schools to conduct screening after a suicide. The population targeted should include the entire school body; however, if not all, at least those peers with pre-existing social risk, peripheral peers, and close friends. The smaller student population of schools in rural Australia would make whole school screening less of a logistical issue. While there needs to be further research to determine the most efficacious screening tool for use in Australia, it is recommended that screening be a mandatory process at a high school following a student suicide death.

Interventions: Who, when, and how long

Most schools were inconsistent in their response following a suicide. Counselling services, when offered, were mostly time-limited and generally required students to self-refer. The schools also reinforced a rapid 'back to normal' routine. As a consequence, most of the participants did not attend counselling. Unfortunately, this may have suggested that participants were coping and, as such, did not require support when this was not the case. A number of the participants argued that counselling was not offered at the time when they needed it; immediately after the death was too soon, but when they were ready to talk about their grief, the counselling was no longer available. Brent and colleagues (1993) had previously identified the mismatch between brief school interventions and the longer-term

needs of bereaved young people. This was reinforced by more recent findings (Swanson & Colman, 2013) and the results from the current study. Many of the participants continued to experience debilitating issues for between two and three years afterwards, but these issues had not been addressed.

There is a need for active postvention following a suicide, and there are a number of first-response type models developed and in operation. These include the Local Outreach to Suicide Survivors Program (LOSS) in the USA (Campbell, Cataldie, McIntosh, & Millet, 2004), as well as the StandBy Response Service in Australia (Comans, Visser, & Scuffham, 2013). The StandBy Response Service offers a proactive first response to those exposed to a suicide, and has developed a Critical Postvention Response (CPR) (United Synergies, 2014)—a community based project to address a suicide crisis in community. Where available, schools should consider building such services into their postvention guidelines or protocols.

The response from schools to a student suicide should comprise a staged hierarchy of interventions, beginning with an initial response that focuses on the whole school population. The initial intervention focus should be based on providing support that is consistent with a psychological first aid approach to ensure safety,

psychological support, comfort, and protection from further harm (Raphael, 2005). This initial response should occur in the first week following the death.

While most students are able to engage quickly back into their schedules and daily routine without significant emotional disturbance, other students who are identified at risk, whether by screening or other means, should be regularly monitored and their risk status reviewed. This monitoring may need to be ongoing, especially for those students identified as at risk before the death. Screening and monitoring should occur from this first week and counselling interviews offered, even if these are simply to make contact with young people and ask them how they are going.

Participants were largely resistant to counselling interventions and this seemed to be because most were unsure exactly what counselling might entail. Better promotion of services can make explicit exactly what services are offered and how they are delivered. Schools need to be proactive in providing support, ensuring students can attend without too much effort, and make direct contact with those students identified as at risk via screening. A passive response that relies on distressed young people seeking out support is unlikely to be successful (McMenamy et al., 2008). Participants actively avoided seeking support because

doing so recognised their friend had died, and some were not prepared to accept this in the initial aftermath. The resolution of grief associated with suicide bereavement may come in later weeks, or months, when the young person is ready and the time is right. For this reason, schools need to proactively offer interventions and support for a much longer period of time.

It is recommended that schools develop a hierarchy of interventions for implementation following a student suicide. This should commence with a first-response type model with rural schools determining the availability of first-response services (such as StandBy's CPR program) in their particular location that could be utilised or adopted. Consistent with recent evidence, schools should consider that any exposure to a peer's suicide is relevant and hence postvention responses should include all students (Swanson & Colman, 2013). Intervention and counselling should be based on an active model of identification and care, and offered for a period of up to two years. School counselling services also need to consider the broader health concerns for young people, not just the risk of suicidal behaviour. The specifics of intervention hierarchies should be written into postvention guidelines, which are then detailed in individual response plans for rural schools.

Social media: Facebook

A number of issues were associated with social media, specifically Facebook, for participants following a friend's suicide. A positive benefit was the immediacy of information broadcast by Facebook. Less positive were the derogatory and demeaning comments often posted about the deceased, and to the deceased's Facebook page, which was then shared with other friends.

There are three areas where Facebook could assist following a suicide death. The first involves the deceased's Facebook account and restricting activity immediately after a user's death. While Facebook provides the potential for removal or memorialisation of a deceased person's account, this process requires verification that the informant is an immediate family member or executor. The location of these instructions on Facebook is not readily obvious. It is unlikely that parents would think about this action in the immediate time period after their daughter or son's death. However, it is during this immediate time period, one or two weeks after the suicide that inappropriate and negative comments are made on Facebook.

Facebook could simplify the access to information about how to respond when a user dies, and could also allow a temporary suspension that ceases action on an account. This could be initiated by someone (perhaps a friend) to take effect for a

period of two weeks until more formal verification is supplied by the family. The family could then decide whether to close the account or have it reconstituted as a memorial site that they can moderate. Alternatively, key search words such as RIP, suicide, or death, could alert Facebook staff moderators to make enquiries and temporarily suspend or place a stop on an account, pending contact from family or others.

The second area of assistance for Facebook is offering more proactive support for young people who may be suicidal, and who are expressing suicidal content on their Facebook page. Facebook has a contact page for reporting suicidal content, although anecdotal reports question the appropriateness of Facebook's responses (Facebook, 2011a). Facebook also lists a help page "How do I help someone who's posted suicidal content on Facebook?" (Facebook, 2014), which includes links to suicide awareness resources available primarily in Western countries.

The use of predictive technology could be extended to all suicide text content with an Australian focus made by young people on Facebook. Such content could prompt an automated help response that provides contact numbers for Lifeline, Kids Helpline, and other 24-hour contact services. Such a response is already occurring in the USA and Canada (Facebook, 2011b). This information could also be

delivered via a message from a Facebook moderator to promote and encourage contact with help and support services.

The third area of assistance is promotion of help-seeking information about suicide. Facebook, and other social media platforms, could promote direct advertising of relevant organisations and services to young people. Advertisements could also be targeted at particular age groups, and users who live and work in certain high-risk occupations and locations. Facebook already collects demographic information as part of its registration process (Facebook, 2013b). Rights and responsibilities listed by Facebook include automatic permission to use profile information with commercial, sponsored or related content. This information could target usage, such as young people who have discussed or searched mental-health or suicide-related material. Facebook could also promote particular help services such as Lifeline, Youthbeyondblue, and the Australian Psychological Society's (APS) 'Find a Psychologist Service' (The Australian Psychological Society, 2014).

It is recommended that Facebook facilitate the more timely suspension of a deceased Facebook user's account; extend the availability of its predictive technology to detect the use of suicide language by young people; and actively promote mental health and support services amongst users.

Improved mental health literacy

This study highlighted that mental health literacy was generally poor in schools and among young people residing in rural communities. Many services expressed a clear reluctance to discuss the topic of suicide. However, it was also clear that participants talked about suicide, and predominantly with each other. While there are legitimate concerns about normalising or romanticising suicide (Callaghan, 1996), without broader discussion of the subject, the opportunity is missed to inform young people with reasoned dialogue to balance what they may hear from peers and others.

Increased mental health literacy has a strong relationship with increased help-seeking behaviour, which in turn can support suicide prevention (Miller, 2009). Increased mental health literacy of young people can improve knowledge of risk factors and reach those at risk more effectively (Doan, Roggenbaum, et al., 2012). It can also address the issue of confidentiality that often deters young people from seeking assistance. Improved mental health literacy in schools and the community can assist young peers to better respond to and assist their friends and themselves.

Young people who are exposed to negative stereotypes about mental illness, which are often perpetuated in the media, can internalise these attitudes and develop stigma towards people who have mental illness. Increased mental health literacy in

schools and communities can begin to dismantle stigma. Programs about mental health and mental illness, such as beyondblue and Youthbeyondblue (beyondblue, 2014), begin to alter the perception that mental illness is a weakness rather than a sickness (Jorm & Wright, 2008).

While the evidence base is equivocal about the impact of suicide prevention programs in schools (Miller, 2009), there is a need to increase the knowledge and skills of school gatekeepers who generally have limited skills in identification and recognition of students at risk (Gould, Greenberg, et al., 2003). Improved mental health literacy can assist school personnel to recognise suicidal behaviour and inform appropriate staff (Lieberman et al., 2006).

Given the multidirectional connections between health and wellbeing, empowerment, participation, educational outcomes, actions and outcomes, the impetus to discuss suicide and mental health requires a broad inter-sectoral approach (Directorate General for Health and Consumers, 2008). It is recommended that improved mental health literacy, and a focus on suicide, be an immediate priority of the Australian Government. This can then inform State and Territory Government approaches, as well as the non-government sector. The current enquiry into suicide and self-harm among young people in Australia (Australian

Human Rights Commission, 2014) provides a starting point for this process. It is critical that this discourse address the dominance of privileged and powerful voices that offer opinions about those who experience mental illness and suicide over the perspectives of others who actually experience mental illness and suicide. Lack of inclusion of people with lived experience reinforces them as the object of the discourse and not a participant (Kesic, Ducat, & Thomas, 2012).

Comment on the chosen methodology

The mixed-methods approach selected for this study allowed participants to talk of their experience of losing a friend to suicide, and also provided quantitative information about this experience. The primary qualitative and supplementary quantitative focus (QUAL + quan) promoted both explanation and understanding. Such an approach is consistent with recommendations to improve the methodological breadth of published research in suicidology (Hjelmeland & Knizek, 2010).

Narrative analysis informed the interpretation of the participants' stories. It allowed examination of the event, and how this was influenced by societal discourse. For most of the participants, this was their first opportunity to tell their story in a non-counselling or therapeutic session. The process of sharing stories was described as

cathartic for the participants; it had meaning for them and they were hopeful their experience would assist others.

One of the participants, Mick, recently contacted me over social media to enquire about the progress of the research. Mick demonstrated a propensity for risk-taking and was one of two participants for whom I held some concerns following interviews. Now, some fifteen months after his interview, and with news that he was now living and working with his parents overseas, I felt some relief. This also caused me to reflect that the narratives of the participants described in this study were very much bound in the context of that time when they were interviewed. My aim to be respectful and honest presenting their experience also needed to recognise that their stories will change over time. They will ultimately construct different meanings about their experience: some good, some bad, and some both.

Viewing this experience solely through a trauma lens can result in needs not being appropriately identified (Raphael, 2005). The psychological distress of the participants, as a response to the suicide death of their friend, is an important consideration for this study as it helps to inform and guide appropriate interventions. However, it is not a defining point of these participants. They demonstrated caring and compassion towards their friend who died, as well as

their own friends and families. As a researcher, the opportunity to share their experience was as humbling as it was informative.

Strengths and limitations of the current study

All research is characterised by the strengths and weaknesses of the design. One strength of this study was the active and engaged participation of eighteen young people from four different rural locations who had high exposure to young people who died by suicide and had stayed in their location following this exposure. Notwithstanding participant recruitment issues already discussed, engaging more young people in the study would have increased the representativeness of the sample. However, the intention of the research was to explore the experience of these rural participants and offer insights into their worlds. The small, purposeful sample allowed for information-rich cases and in-depth study of this population (Polkinghorne, 2005).

Purposeful sampling did influence some of the presentations. For example, the majority of the participants from Location C came from a specific school. They shared a number of pre-existing risk factors (related to family and school) that had resulted in their attendance at that school. These risk factors perhaps moderated their response to the suicide death of their friend, and most of these participants

had attenuated symptoms as quantified by the standardised measures. Other schools in Location C did not support their students being involved in the study, meaning that results from this location are dominated by the higher risk population.

Another strength of the study was providing an opportunity for rural young people to be heard as part of the population of those bereaved by suicide. Young people are often marginalised, with decisions about their care and support usually made by adults on their behalf. This study sought to empower participants, recognise their voice, and support their dignity and right to participate in research that was seeking to determine ways to best support them. The participants acknowledged this and were grateful for the opportunity to be involved. Despite their own issues, they were hopeful their input would be of value to others.

A limitation of the study may have been the varying time period between the suicide death and the research interview. For the participants, this ranged from three months to eight years, although the majority were interviewed within two years of the death. Apart from possible recall bias, distinct reactions to the suicide death may have been mediated by this time factor. Young people with a more recent experience of death would be expected to grieve more openly, and be more

distressed than someone for whom the death was two or three years ago. The troubling issue was that, for many participants, their experience of suicide (friends and family) was not restricted to one death. Nine of the participants were bereaved by two, and some up to four, suicide deaths of friends. Whatever time trajectory of grief the participants might experience, this was disrupted by their multiple grief experience.

Future research

There are a number of recommendations for future research that could follow from the findings of this study.

Broadening the data base

This study provided preliminary data about the suicide bereavement experience of young people in rural Australia. The exploratory nature of this research limits generalisations to the wider population and requires verification using a larger community sample. Expanding this research would allow for greater comparison between age groups (for example, 12-15 years; 15-18 years; 18-21 years) over time, and also between different locations. This could provide for tailoring of specific interventions targeted at certain age groups. Cross-location comparisons can also inform specific geographic issues for suicide bereavement support. This could

include different population comparisons as smaller communities are at higher risk of male suicide, and larger populations would be expected to have access to a greater range of services.

Increased participant numbers can also allow for more robust comparisons between different categories of friendship and in relation to the quantitative measures. Such comparison could consider the different level of risk that is associated with close friends, as opposed to other young people more peripherally associated with the young person who died. The current research involved young people who expressed interest and agreed to participate. Young people more peripherally associated with a suicide death may be less likely to engage in research, yet their participation is crucial to help understanding and ultimately frame interventions that offer support. Methods to engage these young people need to be considered.

Rural vs Urban

Comparisons between rural and urban young people who lose a friend to suicide would assist in determining qualitative and quantitative differences between these groups based on residence and the social and community factors known to be unique to rural communities. Comparisons between age groups, as identified

above, would further explore this experience, as would those staying in the community post-death compared to those leaving.

Longitudinal studies

The bereavement experience of most of the participants ranged from three months to two years. Notwithstanding interventions that may be offered over this time, longitudinal follow-up with young people bereaved by suicide can consider the outcomes and challenges that may arise for this group of young people as they move through adolescence and into early adulthood. Longitudinal data may highlight patterns of risks, as well as potential strengths, that can change over time.

Aboriginal young people

Cultural diversity was a potential limitation in the study. Only one participant identified as being of Aboriginal or Torres Strait Islander origin. As such, any conclusions drawn must be seen within a broader Anglo-Australian perspective. As identified in Chapter 2, Aboriginal and Torres Strait Islander young people have a higher rate of suicide than the non-Indigenous population, and the risk of suicide in Indigenous communities is often compounded by historical and socio-cultural issues. As such, the bereavement experience of Aboriginal and Torres Strait Islander young people is likely to be quite different to non-Indigenous young people. The

present study did not actively recruit Aboriginal and Torres Strait Islander young people. Future research must focus on the unique needs of this particular community of young people.

Summary

This thesis commenced with a quote drawn from an initial pilot study examining youth suicide bereavement.

> *It feels as though every time I go back there it is to say goodbye or for another funeral. On the drive there is this stretch just before you get in, probably about fifteen minutes before you get in, and I get so tense and in the pit of my stomach I feel sick. And I just think, this used to be my home, this used to be a place I loved. Now I struggle to even get back there to say hello. I don't like going back there anymore* (Angel, 2009).

The distress, grief, and sadness inherent in those words prompted the need for exploration of the experience of rural Australian young people who lose a close friend to suicide, and continue to stay in their rural town. The current research aimed to understand how rural young people live through and with the suicide death of a friend; whether there are adverse or positive outcomes from exposure to suicide; and what suggestions young people could offer for support following such an event. Until now, the experiences of bereaved young people have not been explored, yet this experience is vital to help inform appropriate interventions.

Overall, rural young people who lose a friend to suicide incur stigma and distress that is not mediated by the popular notion of rural connectedness. Bereaved young people focused on the wellbeing of their close friends to ensure their safety, but in doing so they largely ignored their own personal health and wellbeing. The importance of exploring the experience of rural young people bereaved by a friend's suicide, and the need to improve literacy about suicide, is highlighted by the words of Bron, one of the study participants:

> *Hidden, hidden always hidden. Just cause of that whole like the taboo of talking about it, like there was so many people who think that it is a sin to commit suicide, or that like people who have mental illness are just crazy.*

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Appendix 1

Initial Data Codes – *Phase two*

Initial Codes – Adam (B1)
1. Transmission from friend's suicide
2. Disbelief
3. Reaction to death/s.
4. Uncertain how to react to family of person who suicided.
5. Exaggerate friendship closeness
6. Responding/coping with suicide
7. School and community response to suicide-family.
8. Community - stigma/not know how to respond or don t respond.
9. Tragedy of lost lives.
10. Gossip following suicide.
11. Media - stigma?
12. Community attitudes to suicide/mental health
13. Schools to offer more - big counselling groups?
14. Schools - groups over individual counselling.
15. Friends response - limited/unsure to respond.
16. Responding to family - own awkwardness.
17. Facebook.
18. Community Stigma.
19. Managing own response - move on try to forget.

Initial Codes – Ben (B2)
1. Family push for someone with same experience to talk.
2. Discomfort providing support role.
3. Guilt within family
4. Friends support for each other.
5. Facebook -friends exaggerating their friendship
6. School time- limited response?
7. Community support.
8. Community awareness - suicide and mental health
9. Community gossip and need to know.
10. Memorials
11. Community response - two faced?
12. Post traumatic growth?
13. Media response.
14. Unpreparedness for youth suicide.
15. Guilt/blame about not seeing it coming.

Initial Codes – Nadia (B3)
1. Relationships
2. Responses from friends
3. Responses from family
4. Religion
5. Lack of support.
6. What I needed
7. Response from school.
8. Impact on me.
9. Stigma

Initial Codes – Amy (B4)
1. Uncertainty of own feelings and response to loss
2. Uncertainty of response
3. Disbelief of the act

4. School reluctance to give information - fear??/pretend it hasn t happened? /How the schools release information.
5. Compulsory attendance at sessions after suicide death.
6. Disclosing to other friends about their own distress.
7. Clinical focus seen as deterrent to participating.
8. Coping with A&D
9. Coping presenters vs. non-coping presenters
10. Dismissive of young people's views and for support
11. Generational views about suicide and stigma
12. Service gatekeeping
13. Looking out for other friends
14. Guilt - Not recognising suicidality in friend
15. Facebook
16. Intoxication - alcohol associated with the death
17.Parents response/support
18. Passive support dependent on young person coming forward.
19. Memorial or some activity to share with friends
20. Religious support via school
21. Rumours without clear information dissemination
22. Media role
23. Flexible help options
24. Reflection about own life – age with deceased
25. Hearing the news – on Facebook.

Initial Codes – Mick (B5)
1. Support from the community following suicide
2. Uncertainty of own feelings and response to loss
3. Community Support
4. Rumours in community/amongst friends
5. Importance of memorials
6. Importance of friends to support during bereavement
7. Availability of other friends to provide support
8. Isolating from others - fear of friends dying
9. Denying help

Initial Codes – Brad (B6)
1. Denial to news -viewed with disbelief, a joke.
2. Facebook as medium to disseminate news
3. Youth community response - support
4. School Counsellors
5. Facebook - conveying the message
6. Family Support
7. Misrepresenting or embellishing the memory of the deceased friend
8. Vigilance about others
9. Talking about suicide
10. Interview Process
11. Not wanting formal support

Initial Codes – Sue (B7)
1. No expectation that friend would suicide
2. Finding out the news - graphic delivery of police but only at that school.
3. Facebook
4. Rumours
5. Clarifying the real story - addressing the rumours
6. Relating/Reacting to deceased parents/family.
7. Own stigma and reaction to family
8. School response
9. Closeness and other friends
10. Thoughts about why?
11. Own parents response.
12. Later impact on self.

13. Other friends coping.
14. Isolating
15. Stigma
16. Memorials.
17. Others letting go.
18. Talking to stranger - someone not known.
19. Compulsory help after suicide for young people.
20. Entitlement for help.
21. Interview process.

Initial Codes – Amber (B8)
1.Facebook and ambiguous messages
2. Disbelief
3. Rumours
4. Peer support
5. Other experience of death helps coping
6. Reluctance to access support-counsellors. (own)
7. Flexibility of counsellor access is important
8. Memorial
9. Response or anticipation of the research interview.
10. Hierarchy of friends and who is upset.
11. Knowing how to respond to close friends.
12. Explanation of death - why?
13. The impact on friends - support and look out for others.
14. Deservedness.
15. Forced help - no
16. Providing information about the suicide.
17. Friends as first point of contact for support

Initial Codes - Zac (B9)
1. Facebook.
2. Impact - own risk of harm
3. Guilt about knowing?
4. Coping - alcohol.
5. Family Reaction.
6. Memorials -
7. Trauma - finding body.
8. Coping- friends
9. Despair over ongoing deaths.
10. Counsellors - feeling confident in their skills/intent.
11. Coping - other drugs.
12. Response to interview.

Initial Codes – Rachel (B10)
1. Comprehending the death - age and ability to comprehend.
2. Suicide death worse than other death.
3. Avoiding reality of the suicide death - ambiguity about need to know.
4. Rumours about the death.
5. The loss at young age and friendships
6. Missing the friend
7. Small town impact.
8. Withdrawl from friends
9. Coping and continuing bonds
10. Help via people with suicide experience.
11. Effect of multiple suicide deaths.
12. Coping - drugs and alcohol.
13. Deservedness
14. Impact later from the suicides
15. Their decision to suicide.
16. Survivor guilt.

17. Memorials.
18. Unwillingness to seek formal help.

Initial Codes – Lauren (B11)
1. Rumours.
2. Facebook.
3. Getting the real correct information.
4. Drinking to cope.
5. Friends
6. Community Support
7. Impact on own life.
8. Own deservedness.
9. Seeking support.
10. Helping others.
11. Importance of talking.
12. Memorials and importance of remembering.

Initial Codes – John (B12)
1. Surprise-shock at decision.
2. News via Facebook
3. Reason for death and getting information
4. Coping - drinking
5. Social ramifications from the death
6. Not wanting others to know.
7. Impact
8. View about the suicide.
9. Community silence about suicide.
10. Counselling and talking about it.
11. Rumours on Facebook.
12. Support from friends family.
13. Deservedness.
14. What helps-hinders?
15. People who over-represent their friendship.
16. Need for counsellors to have experience and understanding in this area.

Initial Codes – Bronte (B13)
1. Facebook
2. Not wanting to talk about for fear of upsetting.
3. Disbelief
4. Coping - avoidance
5. Coping by seeing how others (girlfriend) is managing
6. Stigma
7. Not seeking counsellor support.
8. Memorial to celebrate and grieve.
9. Despair - nothing helps
10. Resistance by family to talk.
11. Blame on others for causing the suicide and impact on others.
12. Compounding experience of other deaths
13. Friend access important to deal with distress.

Initial Codes – Belinda (B14)
1. Reaction to news of death - shock disbelief numb.
2. Impact on effect of the family.
3. Impact on self
4. Funeral and ceremony not helpful.
5. First experience of death.
6. Not wanting help.
7. Not accepting the death.
8. Modelling/Importance of family response to influence help.
9. Shame -resistance to family

10. Friends support.
11. Recognising need to talk is important.
12. Accumulation of death experience.
13. Deservedness.
14. Facebook rumours.
15. Facebook helps.
16. Own stigma.
17. Seek support from friends.

Initial Codes – Kate (B15)
1. Survivor Guilt
2. Finding out.
3. Impact
4. School Response.
5. Friends Response
6. Family Response.
7. Other supports
8. Coping - alcohol
9. Responding to friend's family.
10. Looking after others first
11. About the suicide decision.
12. Memorials
13. Continuing bonds
14. Stigma.
15. Deservedness
16. Supports - other services - headspace.
17. Other suicide deaths - impact
18. Picking up on friend's distress - suicidality.
19. Forced counselling following suicide.

Initial Codes – Skye (B16)
1. Initial response
2. School Response.
3. Facebook and false friends comments
4. Information about the deaths
5. Responding to friends.
6. Stigma?
7. Own changes?
8. Supports.
9. Memorials
10. Interview response.

Initial Codes – Bron (B17)
1. Reaction - disbelief.
2. Reason for suicide - relationship issue.
3. Friends stigma - not talking about it
4. Blame on others (girlfriend)
5. Avoidance or task-focused coping?
6. School Response.
7. Deal with it on own.
8. Deal with it without own family support.
9. Impact on self.
10. Facebook
11. Stigma about suicide - rural towns and size of town
12. Own trauma can affect suicide ideation.
13. Support from friends critical.
14. School determining closeness - miss out?
15. Own denial of support.
16. Time-limited school response.
17. Need to know about how they died?

18. Expecting the suicide?
19. Local Media?
20. Facebook posting to support others.
21. Desired school/community response.
22. Response of other friends-closeness

Initial Codes – Ed (B18)
1. Last contact.
2. Hearing the news from school.
3. Reason for suicide?
4. Own response - shock no grief.
5. School response.
6. Response from other students at school - funeral.
7. Not going to funeral.
8. Rumours.
9. The friend being bullied.
10. Need to know
11. Distancing self from others - withdrawal?
12. Own family response.
13. Response from other friends to self.
14. Others stating their closeness as friends when not the case.
15. School community response - keeping it quiet.
16. Community more open?
17. Media exposure.
18. Own coping and impact.
19. Helping others.
20. Making student support compulsory.
21. Contagion?
22. Effect of talking about suicide.
23. Different distress amongst friends.

Note: (Bnumber) is a participant code, with the number referring to the order in which participants were interviewed. This code is used in place of pseudonyms in Appendix 15.

Appendix 2

MEDIA RELEASE

Helping rural young people affected by a friend's suicide

Researchers at the University of New England are talking to young people living in rural areas about their experience of losing a friend to suicide. By gaining an understanding of their experience, the researchers hope to develop a framework for understanding similarly bereaved young people in future, and to help inform Government policy and procedure for use in schools and in health and community services to assist services after a suicide occurs.

Mr Warren Bartik and Associate Professor Myfanwy Maple from UNE's School of Health and Dr Helen Edwards from UNE's School of Education are seeking young people, aged 12 to 24 at the time they experienced the death and living in rural Australia, who would be willing to share their experiences of the suicide death of a friend.

Mr Bartik, a clinical psychologist and mental health specialist, will be conducting interviews with participants as part of his Doctoral research. "Young people closely

affected by suicide are able to offer a unique insight into suicide," he said, "allowing us to challenge assumptions, develop more appropriate prevention strategies, and understand the phenomenon more broadly. As suicide is unlikely to cease entirely, it is vital that we understand the experiences of those most closely affected, whose lives are changed forever."

Associate Professor Maple has conducted award-winning research over the past ten years that is helping to support the parents of young people who have died through suicide. This project, she said, was encouraging bereaved young people to talk about their grief, and how a friend's death had affected their lives. "To date, responses to youth suicide have primarily focused on prevention," she explained. "While preventative work is vital, such a focus ignores the experiences of those most intimately involved in the suicide death of a young person." The researchers said that all participants, and any information they provided to the research project, would be treated confidentially. Participants under the age of 18 will need their parents' permission to be interviewed.

For more information on the project, or to discuss the possibility of participating, please phone Warren Bartik on 0429 100 091 or at UNE on (02) 6773 2462 or email wbartik2@une.edu.au

Or Associate Professor Myfanwy Maple at UNE on (02) 6773 3661.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No.HE11/178, Valid to 20/12/2013).

Appendix 3

MEDIA EXPOSURE

Print
Port Macquarie News 17/9/2012
Port Macquarie News 22/10/2012
The North West Star 6/2/2013
The North West Star 7/2/2013
The North West Star 12/2/2013
The Armidale Express 15/2/2013
The Border Mail 21/3/2013
Fraser Coast Chronicle 23/2/2013
Northern Daily Leader 11/10/2013

Radio
ABC North West Queensland 12/2/2013 (interview)
ABC New England North West 11/10/2013 (interview)
ABC New England North West 15/8/2013 (interview)

Other
Facebook - Hastings Youth Page 17/2/2013
Facebook – Albury-Wodonga needs headspace 21/3/2013
Facebook – Young People Ahead 8/2/2013
Facebook – Mount Isa Positions Vacant and Work Wanted 11/2/2013
Campus Daily.com.au 13/2/2013
Wn.com 13/2/2013
APS Albury/Wodonga Branch Network Meeting 26/3/2013
Australian Clearing House for Youth Studies 28/2/2013
University of New England (Blog) CRN for Mental Health and Well-being 20/2/2013
University of New England (Blog) CRN for Mental Health and Well-being 26/2/2013
Queensland Voice for Mental Health Inc. 3/3/2013

Appendix 4

SOCIAL MEDIA POSTING

Can you help out?

Warren Bartik from the University of New England is doing a study for rural young people aged between 12 and 24 years who have lost a friend to suicide. One of the aims of the study is to help develop ways to better support young people so it is important that young people's views are included. The study will involve filling out some questionnaires and an interview. Any information provided would be treated confidentially. Participants under the age of 18 will need their parents' permission to be interviewed. If you think you can be involved or know of someone else who might be interested, email Warren at wbartik2@une.edu.au or phone 0429100091.

Appendix 5

PARENT/GUARDIAN INFORMATION FORM

Information Sheet for Parent/Guardian

(Children and Young People participants aged under 18 years)

Suicide – the bereavement experience of rural young people

I would like to invite your child to participate in my research. I am conducting a research project for my PhD at the University of New England on the above topic. The details of the study follow and I hope you will consider your child being involved.

This study is for young people who live in rural Australia and have lost a friend to suicide. To date, much research has been undertaken to establish why young people end their lives. Such research has focussed on what can be done to reduce the numbers of young people dying in this manner. While such research is vital, suicide continues to occur, affecting whole communities, paramount among those affected are their siblings and friends. It is important to understand the experiences of these young people and thus this is the objective of this research. Specifically, this study aims to explore how

young people living in rural locations experience the traumatic and sudden death in the context of a friend's suicide death.

To participate in the project children and young people will need to agree to be interviewed by the researcher. Their parents will also need to agree to their participation. During the interviews, one of the researchers, Mr Warren Bartik, will be interested to hear your child talk about their experience of the suicide death of a friend. He will also ask your child to fill in the Prolonged Grief Inventory and some other self-report questionnaires that ask about depression and anxiety. The interviews will take place at a pre-determined location of your choice (for example, your home, office, cafe etc.). The length and number of interviews will depend on how much your child wishes to tell. However, it is envisaged that one interview will take place for about 60 – 90 minutes in total. With permission, the interview(s) will be audio-recorded.

Your child is under no obligation to participate in this project and can elect to withdraw from the process at any time. All information gathered, including audio files, will be coded to ensure that only the research team know your child's identity. After a period of five (5) years this data will be destroyed, in keeping with the policies of the University.

The content of these interviews will be highly sensitive and potentially upsetting. All information will be treated with care, so as not to cause unnecessary distress. At any time, you or your child may contact the research team to talk about participation in the study (contact details below). The following are contact numbers of independent counsellors in your local area available to you that can provide immediate crisis care within 24 hours after the interviews if required.

- Life Line: 13 11 14;
- Community Health Centre Counsellors: refer to White Pages under 'c';
- 24 hour Mental Health Crisis Line

Identified harm or risk of harm needs to be balanced against confidentiality and if there is a risk of harm then this information needs to be disclosed to parents/guardians for young people under 18 years. Depending on the type of risk, there may be mandated requirements for the researchers to disclose information to Child Protection and/or other Government agencies.

At any time throughout the research process your child or you may withdraw them from participation. If you choose to do this, all information collected will be destroyed.

The information that your child and others provide will form the basis of one team member's Doctoral Thesis. On completion of the thesis, articles will be written from the findings and it is intended that such papers will be published in journals and presented at conferences. This information may inform policies and procedures to assist schools, health services and community groups respond to young people's needs. On request a summary report will be provided to you. You may, at any time, contact the research team to discuss your child's participation in the study, and to have any questions answered.

Thank you for your interest in this project. If you wish to ask any questions, please contact:

Mr Warren Bartik on (02) 6773 2462

Assoc Prof Myfanwy Maple on (02) 6773 3661

Dr Helen Edwards on (02) 6773 2078

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No.HE11/178, Valid to 20/12/2013).

Should you have any complaints concerning the manner in which the research is conducted, please contact the Research Ethics Officer at the following address:

Research Services

University of New England

Armidale, NSW 2351

Telephone: (02) 6773 3449 Facsimile (02) 6773 3543

Email: ethics@une.edu.au

Thank you for considering this request and I look forward to further contact with you.

Regards

Warren Bartik Ph (MOB) 0429 100 091

or email wbartik2@une.edu.au

Appendix 6

PARTICIPANT INFORMATION FORM (18 years and over)

Participant Information Form

Suicide – the bereavement experience of rural young people

I wish to invite you to participate in my research on the above topic. The details of the study follow and I hope you will consider being involved. I am conducting this research project for my PhD at the University of New England.

This study is for young people who live in rural Australia and have lost a friend to suicide. To date, much research has been undertaken to establish why young people end their lives. Such research has focussed on what can be done to reduce the numbers of young people dying in this manner. While such research is vital, suicide continues to occur, affecting whole communities, paramount among those affected are their siblings and friends. It is important to understand the experiences of these young people and thus this is the objective of this research. Specifically, this study aims to explore how young people living in rural locations experience the traumatic and sudden death in the context of a friend's suicide death.

To participate in this project you will need to agree to be interviewed by the researcher. During the interviews, one of the researchers, Mr Warren Bartik, will be interested to hear you talk about your experience of the suicide death of your friend. He will also ask you to fill in the Prolonged Grief Inventory and some other self-report questionnaires that ask you about depression and anxiety. The interviews will take place at a pre-determined location of your choice (for example, your home, office, etc). The length and number of interviews will depend on how much you wish to tell. However, it is envisaged that one interview will take place for about 60 – 90 minutes in total. With your permission, the interview(s) will be audio-recorded.

You are under no obligation to participate in this project and can elect to withdraw from the process at any time. All information gathered, including audio files, will be coded to ensure that only the research team know your identity. After a period of five (5) years this data will be destroyed, in keeping with the policies of the University.

The content of these interviews will be highly sensitive and potentially upsetting. All information will be treated with care, so as not to cause you unnecessary distress. At any time, you may contact the research team to talk about your participation (contact details below). The following are contact numbers of independent counsellors in your

local area available to you that can provide immediate crisis care within 24 hours after the interview, if you need to talk further about your experience;

- Life Line: 13 11 14;
- Community Health Centre Counsellors: refer to White Pages under 'c';
- 24 hour Mental health Crisis Line

Identified harm or risk of harm needs to be balanced against confidentiality and if there is a risk of harm then this information needs to be disclosed to parents/guardians for young people under 18 years. Depending on the type of risk, there may be mandated requirements for the researchers to disclose information to Child Protection and/or other Government agencies.

At any time throughout the research process you may withdraw your participation. If you choose to do this, all information collected will be destroyed.

The information that you and others provide will form the basis of one team member's Doctoral Thesis. On completion of the thesis, articles will be written from the findings and it is intended that such papers will be published in journals and presented at conferences. This information may inform policies and procedures to assist schools, health services and community groups respond to young people's needs. On request a

summary report will be provided to you. You may, at any time, contact the research team to discuss your participation in the study, and to have any questions answered.

Thank you for your interest in this project. If you wish to participate in this project or ask any questions, please contact:

Mr Warren Bartik on (02) 6773 2462

Assoc Prof Myfanwy Maple on (02) 6773 3661

Dr Helen Edwards on (02) 6773 2078

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No.HE11/178, Valid to 20/12/2013).

Should you have any complaints concerning the manner in which the research is conducted, please contact the Research Ethics Officer at the following address:

Research Services

University of New England

Armidale, NSW 2351

Telephone: (02) 6773 3449 Facsimile (02) 6773 3543

Email: ethics@une.edu.au

Thank you for considering this request and I look forward to further contact with you.

Warren Bartik

Ph (MOB) 0429 100 091

or email wbartik2@une.edu.au

Appendix 7

PARTICIPANT INFORMATION FORM (16-17 years)

Suicide - the bereavement experience of rural young people

INFORMATION SHEET FOR YOUNG PEOPLE

(Aged 16-17 years)

We wish to invite you to participate in research on the above topic.

Mr Warren Bartik is a psychologist and researcher at the University and Dr Myfanwy Maple and Dr Helen Edwards are lecturers and researchers also at the University. We are currently doing a research study which is trying to find out more about the experience of young people following a suicide death. We are hoping that children and young people who know a friend who died by suicide will help us by taking part in the study. This Information Sheet has the answers to many of the questions that you and your parent(s) may have about the study. There is a lot of information in here so don't worry if it is too much for one read. Just read through a bit at a time if you want.

1) What is the study for and why is it being done?

We hope that by doing this study, we will learn more about what life and other stuff is like for young people who experience the death of a friend to suicide. There is a lot of research about suicide which helps us to understand it and to help people with problems, but no-one has really asked young people for *their* views or stories. This will be one of the first studies in Australia to do this.

2) What would I be asked to do if I took part in the study?

We want to talk to young people about their experiences, so are asking you to take part in an interview. Although we call these 'interviews', they are more like talks or conversations where you tell us about your experience of losing a friend to suicide.

We will also ask you to complete some questionnaires. These questionnaires are not like exams or tests where there are right and wrong answers. They include questions that ask about how you feel and think about yourself. The interview is not a long list of questions to be answered. We might begin with a question like "Tell us about what happened when you heard your friend had died" and you would take it from there.

3) When and where would the interview take place?

The interview can be held wherever is the easiest for people to get to. This might be at your home, the local library or a cafe.

4) Will I be paid for participating in this research study?

Sadly no, we can't pay people to take part in research as it has to be voluntary.

5) What information will the researchers want me to tell them?

We want you to tell us about your experience of your friend dying.
We want you to tell us about things that YOU think are important.
We want you to tell us what you think people should know about what life is really like for young people in your position.

6) Why do you need to audio-record what I tell you?

We record these interviews because we think that what young people are telling us is very important. If we didn't record it we could forget a lot of really important stuff that we'd heard. It is too hard to take notes at an interview, because then you can't concentrate on what the person is saying to you. Think of when you are at school trying to write notes and listen to the teacher at the same time!

Most people that we've interviewed before say that they hate the sound of their voices on tape, but they don't mind the audio - recorder being there. In fact, the microphone is so small that most people don't even bother with it.

7) What will be done with this information that I give?

First, we take the recording and give it to a secretary who types out every word so that we know we haven't missed anything.

When this is being done, the secretary makes sure that no-one's real names are used in the 'transcript' of the interview that is printed out. This makes sure that nobody reading it can tell who has said what at the interview, and so what you say stays confidential.
Then, the researchers read through these typed-out 'transcripts' very carefully, making notes and trying to pick out all of the most interesting and important things that the participants have been telling us. We are looking for things that will help us and other people understand more about how young people experience the suicide death of a friend.
The researchers will write a report at the end of the study so that we can share the information from this study with other researchers and those people who are interested and involved in young people's health.
We also write articles about the study and publish these. Also we talk about the study at meetings and conferences so what we have found out gets to those people able to use the information to help. If we didn't do this, then the young people who helped us by telling their story might feel that they had done this for nothing.

Remember your name will not appear in any of the articles or reports as what you tell us is confidential and private. What we would do is perhaps write that "John (not his real name), said that he gets really worried about the amount of school that he misses."

8) Who will be told about any information that I give?

All the interviews and questionnaires are confidential. What you tell us will stay within the research team, apart from when we report the study as we explained above in point 7. None of what you tell us will become part of any health or social services records or notes.
The only exception to this point is that if someone was to tell us something that indicated that someone was at risk of harm in some manner. Identified harm or risk of harm needs to be balanced against confidentiality and if there is a risk of harm then this information needs to be disclosed to parents/guardians for young people under 18 years. Depending on the type of risk, there may be mandated requirements for the researchers to disclose information to Child Protection and/or other Government agencies.

9) Do I have to take part in this study?

Not at all. You should only take part if you want to and are happy to do it.

10) What will happen if I don't want to take part?

Nothing at all. You have every right to say that you would rather not take part.

11) Can I change my mind if I decide to participate?

Yes. Participants can choose to leave the study at any time and nothing at all will be said, apart from 'Thank you very much for thinking about taking part'. You can also choose to discuss or not discuss any aspect of your experience - whatever you feel most comfortable with.

12) Will the study benefit me in any way?

We can't promise that you will get any benefit from taking part. However, you might feel that by describing your experiences, you may be helping readers of the study's reports and findings to get a better understanding of what having a friend die by suicide is like for young people.

13) Have you got permission to do this study?

Yes. We have permission from the Ethics Committee at the University of New England Research Ethics Committee. This group has looked carefully at this study and have approved it. The Approval Number is HE11/178, and it is valid until 20/12/2013

14) What if I have other questions about the study?

Please contact the main researcher, Mr Warren Bartik at any time. His office phone number is 02 6773 2462. You can also call Dr Myf Maple on 02 6773 3661 or Dr Helen Edwards on (02) 6773 2078. Should you have any complaints concerning the way this research is being conducted, please contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543
Email: ethics@une.edu.au

15) What if I feel that I would like to talk to someone after the interview about any thoughts, feelings or problems that I have?

You may contact any member of the research team, and if you ask Warren, Myf or Helen they could put you in touch with other people who have experience in counselling and listening to young people.

Please keep this information sheet as you might want to discuss it with friends, family or relatives. Thanks a lot for taking the time to read this and for any help that you are able to give us with this study.

Warren Bartik, Myf Maple, Helen Edwards.

Appendix 8

PARTICIPANT INFORMATION FORM (14-15 years)

Suicide - the bereavement experience of rural young people

INFORMATION SHEET FOR YOUNG PEOPLE

(Aged 14-15years)

We wish to invite you to participate in research on the above topic.

Mr Warren Bartik is a psychologist and researcher at the University and Dr Myfanwy Maple and Dr Helen Edwards are lecturers and researchers also at the University. We are currently doing a research study which is trying to find out more about the experience of young people following a suicide death. We are hoping that children and young people who know a friend who died by suicide will help us by taking part in the study. This Information Sheet has the answers to many of the questions that you and your parent(s) may have about the study. There is a lot of information in here so don't worry if it is too much for one read. Just read through a bit at a time if you want.

1) What is the study for and why is it being done?

We hope that by doing this study, we will learn more about what life and other stuff is like for children and young people who experience the death of a friend to suicide. There is a lot of research about suicide which helps us to understand it and to help people with problems, but no-one has really asked children and young people for *their* views or stories. This will be one of the first studies in Australia to do this.

2) What would I be asked to do if I took part in the study?

We want to talk to young people about their experiences, so are asking you to take part in an interview. Although we call these 'interviews', they are more like talks or conversations where you tell us about your experience of losing a friend to suicide.

We will also ask you to complete some questionnaires. These questionnaires are not like exams or tests where there are right and wrong answers. They include questions that ask about how you feel and think about yourself. The interview is not a long list of questions to be answered. We might begin with a question like "Tell us about what happened when you heard your friend had died" and you would take it from there.

3) When and where would the interview take place?

The interview can be held wherever is the easiest for people to get to. This might be at your home, the local library or a cafe.

4) Will I be paid for participating in this research study?

Sadly no, we can't pay people to take part in research as it has to be voluntary.

5) What information will the researchers want me to tell them?

We want you to tell us about your experience of your friend dying.
We want you to tell us about things that YOU think are important.
We want you to tell us what you think people should know about what life is really like for young people in your position.

6) Why do you need to audio-record what I tell you?

We record these interviews because we think that what young people are telling us is very important. If we didn't record it we could forget a lot of really important stuff that we'd heard. It is too hard to take notes at an interview, because then you can't concentrate on what the person is saying to you. Think of when you are at school trying to write notes and listen to the teacher at the same time!

Most people that we've interviewed before say that they hate the sound of their voices on tape, but they don't mind the audio - recorder being there. In fact, the microphone is so small that most people don't even bother about it.

7) What will be done with this information that I give?

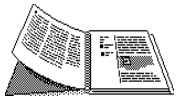
First, we take the recording and give it to a secretary who types out every word so that we know we haven't missed anything. The secretary makes sure that no-one's real names are used in the 'transcript' of the interview that is printed out. This makes sure that nobody reading it can tell who has said what at the interview, and so what you say stays confidential.

Then, the researchers read through these typed-out 'transcripts' very carefully looking for things that will help us to understand more about how children and young people experience the suicide death of a friend.

The researchers will write a report at the end of the study so that we can share the information from this study with those people who are interested and involved with children and young people's health.

We will write articles about the study and publish these. Also we talk about the study at meetings and conferences so what we have found out gets to those people able to use it to help. If we didn't do this, then the children and young people who helped us by telling their story might feel that they had done this for nothing. Remember your name will not appear in any of the articles or reports as what you tell us is confidential and private. What we would do is perhaps write that "John (not his real name), said that he gets really worried about the amount of school that he misses."

8) Who will be told about any information that I give?



All the interviews and questionnaires are confidential. What you tell us will stay within the research team, apart from when we report the study as we explained above in point 7**.** None of what you tell us will become part of any health or social services records or notes.

The only exception to this point is that if someone was to tell us something that indicated that someone was at risk of harm in some manner. Identified harm or risk of harm needs to be balanced against confidentiality and if there is a risk of harm then this information needs to be disclosed to parents/guardians for young people under 18 years. Depending on the type of risk, there may be mandated requirements for the researchers to disclose information to Child Protection and/or other Government agencies."

9) Do I have to take part in this study?

Not at all. You should only take part if you want to and are happy to do it.

10) What will happen if I don't want to take part?

Nothing at all. You have every right to say that you would rather not take part.

11) Can I change my mind if I decide to participate?

Yes. Participants can choose to leave the study at any time and nothing at all will be said, apart from 'Thank you very much for thinking about taking part'. You can also choose to discuss or not discuss any aspect of your experience - whatever you feel most comfortable with.

12) Will the study benefit me in any way?

We can't promise that you will get any benefit from taking part. However, you might feel that by describing your experiences, you may be helping readers of the study's reports and findings to get a better understanding of what having a friend die by suicide is like for young people.

13) Have you got permission to do this study?

Yes. We have permission from the Ethics Committee at the University of New England Research Ethics Committee. This group has looked carefully at this study and have approved it. The Approval Number is HE11/178 and it is valid until 20/12/2013

14) What if I have other questions about the study?

Please contact the main researcher, Mr Warren Bartik at any time. His office phone number is 02 6773 2462. You can also call Dr Myf Maple on 02 6773 3661 or Dr Helen Edwards on (02) 6773 2078. Should you have any complaints concerning the way this research is being conducted, please contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543
Email: ethics@une.edu.au

15) What if I feel that I would like to talk to someone after the interview about any thoughts, feelings or problems that I have?

You may contact any member of the research team, and if you ask Warren, Myf or Helen they could put you in touch with other people who have experience in counselling and listening to children and young people.

Please keep this information sheet as you might want to discuss it with friends, family or relatives. Thanks a lot for taking the time to read this and for any help that you are able to give us with this study.

Warren Bartik, Myf Maple, Helen Edwards.

Appendix 9

PARTICIPANT INFORMATION FORM (12-13 years)

Suicide - the bereavement experience of rural young people

INFORMATION SHEET FOR CHILDREN AND YOUNG PEOPLE (Aged 12-13 years)

We wish to invite you to participate in research on the above topic.

Mr Warren Bartik is a psychologist and researcher at the University and Dr Myfanwy Maple and Dr Helen Edwards are lecturers and researchers also at the University. We are currently doing a research study which is trying to find out more about the experience of young people following a suicide death. We are hoping that children and young people who know a friend who died by suicide will help us by taking part in the study. This Information Sheet has the answers to many of the questions that you and your parent(s) may have about the study. There is a lot of information in here so don't worry if it is too much for one read. Just read through a bit at a time if you want.

1) What is the study for and why is it being done?

We hope that by doing this study, we will learn more about what life and other stuff is like for children and young people who experience the death of a friend to suicide. There is a lot of research about suicide which helps us to understand it and to help people with problems, but no-one has really asked children and young people for *their* views or stories. This will be one of the first studies in Australia to do this.

2) What would I be asked to do if I took part in the study?

We want to talk to young people about their experiences, so are asking you to take part in an interview. Although we call these 'interviews', they are more like talks or conversations where you tell us about your experience of losing a friend to suicide.

We will also ask you to complete some questionnaires. These questionnaires are not like exams or tests where there are right and wrong answers. They include questions that ask about how you feel and think about yourself. The interview is not a long list of questions to be answered. We might begin with a question like "Tell us about what happened when you heard your friend had died" and you would take it from there.

3) When and where would the interview take place?

The interview can be held wherever it is easiest for people to get to. This might be at your home, the local library or a cafe.

4) Will I be paid for participating in this research study?

Sadly no, we can't pay people to take part in research as it has to be voluntary.

5) What information will the researchers want me to tell them?

We want you to tell us about your experience of your friend dying.
We want you to tell us about things that YOU think are important.
We want you to tell us what you think people should know about what life is really like for young people in your position.

6) Why do you need to audio-record what I tell you?

We record these interviews because we think that what young people are telling us is very important. If we didn't record it we could forget a lot of really important stuff that we'd heard. It is too hard to take notes at an interview, because then you can't concentrate on what the person is saying to you. Think of when you are at school trying to write notes and listen to the teacher at the same time!

Most people that we've interviewed before say that they hate the sound of their voices on tape, but they don't mind the audio - recorder being there. In fact, the microphone is so small that most people don't even bother about it.

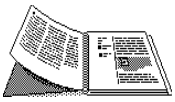
7) What will be done with this information that I give?

First, we take the recording and give it to a secretary who types out every word so that we know we haven't missed anything. The secretary makes sure that no-one's real names are used in

the ‘transcript’ of the interview that is printed out. This makes sure that nobody reading it can tell who has said what at the interview, and so what you say stays confidential.
Then, the researchers read through these typed-out ‘transcripts’ very carefully looking for things that will help us to understand more about how children and young people experience the suicide death of a friend.
The researchers will write a report at the end of the study so that we can share the information from this study with those people who are interested and involved with children and young people’s health.
We will write articles about the study and publish these. Also we talk about the study at meetings and conferences so what we have found out gets to those people able to use it to help. If we didn’t do this, then the children and young people who helped us by telling their story might feel that they had done this for nothing.

Remember your name will not appear in any of the articles or reports as what you tell us is confidential and private. What we would do is perhaps write that “John (not his real name), said that he gets really worried about the amount of school that he misses.”

8) Who will be told about any information that I give?



All the interviews and questionnaires are confidential. What you tell us will stay within the research team, apart from when we report the study as we explained above in point 7. None of what you tell us will become part of any health or social services record or notes.
The only exception to this is if someone was to tell us something that identified there is a risk of harm then this information needs to be disclosed to parents/guardians for young people under 18 years. Depending on the type of risk, there may be mandated requirements for the researchers to disclose information to Child Protection and/or other Government agencies.

9) Do I have to take part in this study?

Not at all. You should only take part if you want to and are happy to do it.

10) What will happen if I don’t want to take part?

Nothing at all. You have every right to say that you would rather not take part.

11) Can I change my mind if I decide to participate?

Yes. Participants can choose to leave the study at any time and nothing at all will be said, apart from ‘Thank you very much for thinking about taking part’. You can also choose to discuss or not discuss any aspect of your experience - whatever you feel most comfortable with.

12) Will the study benefit me in any way?

We can't promise that you will get any benefit from taking part. However, you might feel that by describing your experiences, you may be helping readers of the study's reports and findings to get a better understanding of what having a friend die by suicide is like for young people.

13) Have you got permission to do this study?

Yes. We have permission from the Ethics Committee at the University of New England Research Ethics Committee. This group has looked carefully at this study and have 'passed' it. **The Approval Number is HE11/178, and it is valid until 20/12/2013**

14) What if I have other questions about the study?

Please contact the main researcher, Mr Warren Bartik at any time. His office phone number is 02 6773 2462. You can also call Dr Myf Maple on 02 6773 3661 or Dr Helen Edwards on (02) 6773 2078. Should you have any complaints concerning the way this research is being conducted, please contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543
Email: ethics@une.edu.au

15) What if I feel that I would like to talk to someone after the interview about any thoughts, feelings or problems that I have?

You may contact any member of the research team, and if you ask Warren, Myf or Helen they could put you in touch with other people who have experience in counselling and listening to children and young people.

Please keep this information sheet as you might want to discuss it with friends, family or relatives. Thanks a lot for taking the time to read this and for any help that you are able to give us with this study.

Warren Bartik, Myf Maple, Helen Edwards.

Appendix 10

PARTICIPANT CONSENT FORM (18 years and over)

Consent Form
(Young people aged over 18 years)

Research Project: Suicide - the bereavement experience of rural young people

I, …… have read the information in the Participant Information Form attached and have had any queries satisfactorily answered. By signing this consent form, I agree to be interviewed by the researcher and understand that information gathered will be published appropriately. I understand all information provided by me will be coded so I remain anonymous to all but the research team. I understand that I may withdraw my participation at any time without providing a reason. If I choose to do this, I understand that all information gathered about me will be destroyed and not used in any manner.

I AGREE / DO NOT AGREE to have the interviews audio-recorded (please circle)

…… …/…/…

Signed by Participant date

…… …/…/…

Witnessed by Researcher date

Appendix 11

PARTICIPANT ASSENT FORM (16-17 years)

ASSENT FORM for Young People 16-17 years.

Suicide - the bereavement experience of rural young people

Please write your name after 'I,' and circle the yes/no answer you want.

I, ……., have read the Information Sheet for Young People 16-17 years and any questions I asked have been answered and I understand them. Yes/No

I agree to take part in this work, and I know that I can change my mind at any time. Yes/No

I understand that my identity will remain confidential and all the information I provide will be treated anonymously and anything we talk about will be written about using a pseudonym. Yes/No

I agree that the interview can be audio-recorded and transcribed. Yes/No

…….. …….

Young person Date

…….. …….

Researcher Date

Appendix 12

PARTICIPANT ASSENT FORM (14-15 years)

ASSENT FORM for Young People 14-15 years.

Suicide - the bereavement experience of rural young people

Please write your name after 'I,' and circle the yes/no answer you want.

I, ……., have read the Information Sheet for Young People 14-15 years and any questions I asked have been answered and I understand them. Yes/No

I agree to take part in this work, and I know that I can change my mind at any time. Yes/No

I understand that my identity will remain confidential and all the information I provide will be treated anonymously and anything we talk about will be written about using an invented name

Yes/No

I agree that the interview can be audio-recorded and transcribed. Yes/No

……..	…….
Young person	Date
……..	…….
Researcher	Date

Appendix 13

PARTICIPANT ASSENT FORM (12-13 years)

ASSENT FORM for Children 12-13years.

Suicide - the bereavement experience of rural young people

Please write your name after 'I,' and circle the yes/no answer you want.

I, ……., have read the Information Sheet for Children 12-13 years and any questions I asked have been answered and I understand them. Yes/No

I agree to take part in this work, and I know that I can change my mind at any time. Yes/No

I understand that my identity will remain confidential and all the information I provide will be treated anonymously and anything we talk about will be written about using an invented name. Yes/No

I agree that the interview can be audio-recorded and transcribed. Yes/No

……..	…….
Young person	Date
……..	…….
Researcher	Date

Appendix 14
INTERVIEW INFORMATION FORM

Suicide - the bereavement experience of young people in rural Australia

Interview Guide

Signed Consent form Y \ N

Demographic questions:

Gender ……..

Age ……..

School/university/work …….....

Age at time of friend's death ……

Time since death occurred ……

Rural town of death (if different).....

(Quantitative measures to be administered).

- Coping Inventory for Stressful Situations (CISS)
- Beck Depression Inventory (BDI-II)
- State Trait Assessment Inventory (STAI)
- Prolonged Grief Inventory (PG-13)
- Stigma of Suicide Scale (SOSS)
- Posttraumatic Growth Inventory (PTGI)

Health questions (to be asked).

In general, would you say your health is: Excellent / Very good / Good / Fair / Poor

Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago.

Somewhat better now than one year ago.

About the same as one year ago.

Somewhat worse than one year ago.

Much worse than one year ago.

How often do you drink alcohol?

Never / monthly / 2-4 times a month / 2-3 times a week / 4 or more times a week

How many alcohol drinks do you typically have when drinking?

1-2 / 3-4 / 5-6 / 7-9 / 10 + (type of alcohol……)

(Qualitative) Introduction.

"I would like to start by asking some specific questions about your experience of losing your close friend (friend's name) to suicide. As we talk I may need to take some notes and remember we can stop if you need to at any time to take a break or whatever".

1. Tell me about how you first met (friend).
    a. How did the relationship develop?
    b. How close would you describe your relationship as being – what factors made you feel close to (friend)?
    c. Tell me about the last time you had contact with him/her (in person, phone, internet etc)
    d. Did you have any idea they might take their own life?

2. Tell me about the day they died (or when you found out they had died)?
    a. (prompt: was there exposure, did they see the person post-death, where did the suicide take place, what method was used, what was their initial reaction)

3. Can you tell me about the next few days?
    a. (prompt: sources of support – who was important and who else made contact, was it welcome or unwelcome, was it what you needed)

4. What was your School/ TAFE/ work response to the event?
    a. How was this helpful / unhelpful? In what ways?
    b. What would you have wanted differently from school/tafe/work to help you through this?

5. What was your family/ and friends response to the event?
    a. How was this helpful / unhelpful? In what ways?
    b. What would you have wanted differently from family/ friends to help you through this?

6. How has life changed for you as a result of the suicide? In what ways?

7. What things have been difficult for you due to the death?
    a. (prompt: have you faced stigma? In what ways)
    b. How did the local community respond to the suicide death?

8. What have been the best sources of support?
    a. Have you ever felt that you weren't entitled to get the same level of support (such as family)?

Thank you for talking with me today. I would encourage you to phone, write, send an email, if you feel that you have left anything out or you would like to add to your story in any way.

In the study, where I refer to your story an alias will be used to protect your identity. Would you like to choose the names which will be used for you and your friend?

You: _____ *Friend:* _____

Appendix 15

General health and alcohol use