

Chapter 1

INTRODUCTION

Young people now die by suicide at a greater rate than at any other time in recorded history. In Australia, these deaths most frequently occur in young men, principally from rural areas. For more than 30 years research and policy initiatives have tried to curb this phenomenon, gathering valuable knowledge about those 'at risk' of suicide. Yet, those most intimately affected by the suicide death of a young person – parents, family, and friends -- have not benefited from this attention (Beautrais 1999; Cantor, Neulinger, Roth & Spinks 1999).

Usually, we know death from a distance, like the tragic happenings that lead the nightly news bulletins. In passing we think of those affected and their grief and then we go on with our own lives. In stark contrast, when we experience the death of a loved one, grief overwhelms us. Initially paralysed by their absence, we gradually resume our lives over time. Yet, how we apparently 'get over' grief remains a mystery (Clark 2002). Lay opinion favours a 'time heals all wounds' theory, while social scientists talk about

'phase or stage models'. More recently, a 'continuing bonds' model has started to emerge (Klass 2000; Klass & Marwit 1988; McCabe 2003).

As a direct result of the increasing number of young people dying by suicide, more people are bereaved, with up to six people immediately affected after each suicide (Clark & Goldney 2000). This measure potentially underestimates the number of people grieving each suicide death, the ramifications of which extend more widely (Campbell 1997). Three to four generations can be bereaved: siblings, parents, grandparents, and in some instances, the young person's own offspring (Cantor et al. 1999). More broadly, relatives, friends, and the wider community are also affected.

The plight of those most profoundly affected is not yet understood. As Cantor and his colleagues (1999:89) note, 'Australian and international research has neglected the study of the impact of suicide on the wellbeing of intimates'. This thesis aims to redress this gap in knowledge by specifically addressing the experience of parents following the suicide death of their young adult son or daughter.

Guiding research question

To examine the experience of parents bereaved through the suicide death of their young adult son or daughter, I used a narrative design and in-depth interviews to talk with parents about their story. Guiding this research was the question: *How do parents live through and live with the suicide death of their young adult child?*

Significance of the research

The primary purpose of this study was to explore the experience of parents bereaved through the suicide death of their young adult child. It will become evident in Chapter 3 that the literature provides little direction in understanding these parents' experiences. The present study primarily sought to provide parents with an opportunity to talk about their experiences, in any manner with which they felt comfortable.

The reasoning behind undertaking this study was threefold. First, by exploring parents' experiences I anticipated benefits would later accrue to newly bereaved parents through a deeper understanding of the events from those who had already experienced this traumatic event. Second, professionals working in the suicide field could benefit from parents' insights in suicide prevention and postvention services for families. Third, a

glimpse into the life of the young adult child could provide insight into suicide in this age group, potentially extending the use of preventative programs outside the current focus on risk groups.

Cultural considerations

The study reported in this thesis focused on Anglo–Australian parents and the grief they experienced within their particular cultural milieu. Australia represents a range of other cultural and ethnic groupings, which are not represented in this thesis. Further mention of these cultural constraints is made in Chapter 9.

Definition of terms

Survivors of suicide

A term commonly used to describe individuals bereaved through suicide is ‘survivors of suicide’. Although this is a somewhat awkward term as it can be mistaken as indicating someone who has been unsuccessful in attempting suicide, it is the recognised term in the field for those bereaved through a suicide death. This term is used in this thesis in conjunction with ‘parents bereaved through suicide’ and ‘suicide-bereaved parents’ to describe parents experiencing grief brought on by the suicide death of their young adult son or daughter.

Postvention

'Postvention' is the term used in service provision and professional practice for support services available to people bereaved through suicide. First coined by Shneidman (1972) more than 30 years ago, it has also become the marker term used among researchers in this field.

Overview of thesis

The research reported in this thesis set out to examine the experience of parents who have lived through and are living with the suicide death of their young adult son or daughter. From the data collected in this research, we will see how parents create a public story about their experiences, which does not necessarily reflect their private reality. This private story was accessed in this research through the use of a narrative interview process, where parents were able to share their particular experiences with me.

The private story that parents shared with me comprised three key narrative components that form the basis of the analysis and discussion chapters. Each of these components is played out in diverse ways among this group of parents. While some seem aware that others may have like private stories, others have no way of knowing the private stories of others bereaved in this way. Parents have been silenced through societal expectations of grief and

bereavement, further complicated by suicide death in this instance. This thesis provides an avenue for their voices to be heard.

The current chapter provides the overview and context for this research and defines the terminology used. Chapter 2 begins by presenting Australian statistics and policies relating to suicide among young people and how these influence the ways in which suicide is viewed. Following this, Chapter 3 provides a critique of current grief frameworks, followed by an examination of the bereavement experience of parents in general, and more specifically, the limited research examining parental bereavement through suicide.

The research design and methods are presented in Chapter 4. The narrative method undertaken for this study is described, with emphasis made on the particular narrative approach undertaken, which embraced the framework developed by Polkinghorne (1988). This is followed by a description of the sample, the manner in which the analysis was performed and limitations of the method. This chapter ends with my introducing myself and the way in which I influence the co-construction of these stories in my role as researcher.

Portraits of the study participants, their deceased children and families, are presented in Chapter 5. Each portrait is intended to provide a sense of the family, the interview environment, and the relationship that developed

between each parent and me during the research period. These portraits are used to evoke particularity and document the diversity in the stories. Following this are the three narrative components (plots) abstracted from the parents' stories when narrating their experience of living through and living with the suicide death of their young adult son or daughter.

The first plot, presented in Chapter 6, discusses the barriers parents face that inhibit them from discussing their son or daughter after she or he has suicided. As will be demonstrated in this chapter, Australian social and cultural history has resulted in suicide being viewed as unjustifiable, physically repulsive, and an ambiguous death, thus alienating parents from publicly acknowledging their experience of the death of their daughter or son.

Chapter 7 presents the second plot identified, which introduces the concept of preparedness for the suicide death prior to the event. This narrative presents an argument that some suicide is expected. Established opinion is grounded in the premise that suicide is generally unexpected and the bereavement that follows is traumatic, although there are a few authors who make brief reference to an expectation that a child may suicide. The results of my study demonstrate three levels of preparedness that can be experienced. There is a group of parents who expect their child to suicide. For others the

suicide comes as a complete shock, and the third group who, on reflection, are able to identify signs that indicated a potential risk of suicide. An understanding of preparedness for the suicide is important, as it influences the resultant grief. This chapter concludes with a discussion about preparedness in relation to existing suicide bereavement research literature.

The third plot used by parents to narrate the experience of the suicide death of their young adult son or daughter is presented in Chapter 8. This examines the ways in which parents actively sustain an emotional, spiritual bond with their child after their physical attachment is broken by the death. This narrative adds support for an emerging grief paradigm, focussing on a continued bond between the bereaved and the deceased as elaborated by Klass, Silverman and Nickman (1996), among others. This new paradigm reflects the theory that there is no finalisation of grief, as proposed by earlier grief models. Rather it hypothesises death as a stage in an ongoing relationship, not an endpoint. The transition from grieving the loss to remembering their child is the focus of discussion.

Chapter 9 draws together these three narrative components and examines how parents narrate living through and living with the suicide death of their young adult daughter or son. This chapter identifies the potential of these insights as policy and practice tools to understand diverse parental

experiences of suicide. Adding new dimensions to our understanding of parental suicide bereavement, these three components deepen our understanding of how parents use private and public stories to talk about their son or daughter and how these stories can be shared to further our knowledge of suicide. In this final chapter the strengths and the limitations of the study are examined and discussed and recommendations for the future direction of suicide research are made.

Chapter 2

LITERATURE REVIEW:

SUICIDE

The following two chapters critique preceding research and policy in relation to the two main topic areas that relate to this study. The first provides an historical overview of suicide death, theories of suicide, and the Australian experience of youth suicide. This chapter also presents and critiques the 'risk' framework that has been developed over the past two decades that underpins Australia's response to youth suicide. The second topic area, presented in Chapter 3, reviews contemporary empirical and theoretical understandings of grief and bereavement and how these inform our understanding of the parental experience of losing a young adult child to suicide. Contemporary and emerging grief paradigms are examined, followed by a review of knowledge of parental bereavement. In the final section, research specifically addressing bereavement through the suicide death of a young adult child is presented.

A brief history of suicide

Suicide has existed throughout history among the human race, yet how such a death is viewed by society has changed over time. In the past, reliable statistics of the number of suicide deaths were not kept. Some authors (see Minios 1998 for example) argue that this is still the case, suggesting that some suicide deaths are not recorded as such and thus the true number of suicide deaths remain unknown (Cantor et al. 1999). The historical literature therefore examines the ways that society deals with suicide, not the number of people who die in this way. For example, Lieberman (2003) reports that there are many meanings of suicide, from early biblical suicide, to martyrs who die for their faith or cause today. In recent times, suicide has sometimes been romanticised. The suicide death of grunge rock musician Kurt Cobain in the early 1990s is one example, raising concern about potential copycat suicides occurring in response (Jobes, Berman, O'Carroll, Eastgard & Knickmeyer 1996).

MacDonald and Murphy (1990) trace the history of suicide. They note that in early societies, suicide generally occurred among the old, disabled and humiliated. As society evolved the reasons for suicide and the methods used have changed. In the early Middle Ages, suicide was generally seen as a cure for shame. With the growth of societies and the emergence of large cities, the

rate of suicide reached new heights, causing speculation that lonely people in cities became desperate and took their own life.

Until relatively recently, suicide was viewed as a crime, a type of murder, and a desperate, mortal sin in the opinion of some Christian churches. During the 18th century, this crime was punishable by the State through the reclaiming of personal possessions of the deceased and forbidding a church burial. The deceased's loved ones suffered punishment for the suicidal actions of their relative, and civil law had the power to enact severe sanctions against survivors (Kneiper 1999; Minios 1998). While such sanctions are no longer supported in Western society, the broader community 'is still not completely supportive and helpful to survivors' (Kneiper 1999:358), with the notion of 'good' and 'bad' death prevailing (MacDonald & Murphy 1990:1).

The recent medicalisation of suicide (among other conditions and behaviours) has been driven by the view that suicide is a symptom of a lack of reason. However, Leibermen (2003) argues that suicide is not the passive act this implies. Rather, the powerful meanings behind suicide, and the stance that the suicide completer takes, however misguided, is an active way to deal with what is happening to them both internally and within their social sphere.

Durkheim's (1952) widely known and enduring analysis locates the causes of suicide in the social realm suggesting there are three causes for suicide. The first, known as egotistic suicide is said to be where an individual lacks integration into society. The second, altruistic suicide is said to be where an individual is highly integrated into society and is governed by social customs and habits, yet perceive their suicide to be 'commanded' by a higher power, either religious or political. Third is anomic suicide, where there is lack of regulation in society, or where order is suddenly upset. One example provided by Durkheim (1952) relates to marriage. Marriage, in his view, is seen to regulate and maintain, whereas divorce is seen to deregulate or promote lack of order.

Durkheim's (1952) focus in his theory of suicide was the manner in which interaction between an individual and society takes place. In direct contrast, the fundamental premise underlying suicide prevention today places the emphasis on the individual young person and particular risk factors they may exhibit, and on intervention strategies to promote positive mental health are based on this view.

Youth suicide

The adolescent decade is considered a transitional time between childhood and adulthood dominated by change: physical, emotional, and social (Peterson 2004). It can be a time for both exciting development and desperate loneliness. While most young people emerge from this process relatively unscathed, for some this period of transition marks the onset of a number of health-related issues that may predispose an individual to suicide (Australian Institute of Family Studies 2000; Beautrais 1999; Commonwealth Department of Health and Aged Care 1999; 2000c; Commonwealth Department of Health and Family Services 1997a; 1997b; Graham, Reser, Scuderi, Zubrick, Smith & Turley 2000; Mental Health Branch 2000; Mitchell 2000a).

This complexity of factors is difficult to unravel in particular instances of suicide. Each suicide death of a young person is unique and there is typically no one reason for suicide per se. It is rarely possible to retrospectively reveal factors influencing the myriad of pain that leads a young person to decide to end their own life (Graham et al. 2000). However, over the past few decades a growing body of research has uncovered a diversity of risk factors relating to youth suicide. In response, there is evidence building about resiliency frameworks that aim to promote protective factors within individuals. It is

these understandings of risk and protective factors that inform policies and prevention strategies today.

Within the understandings of the current risk framework, young people who are vulnerable to suicide in Australia are those who have a history of mental illness; have a history of previous suicide attempts or deliberate self-harm; are male; live in rural or remote localities; are of Aboriginal or Torres Strait Islander descent; question their sexual orientation or are gay, lesbian, bisexual, or transgender; or who have experienced individual adversity (Commonwealth Department of Health and Aged Care 1999; 2000c; 2000e; Mitchell 2000b). Each of these risk groups will be examined briefly below, and an evaluation of this risk-based framework will follow.

Mental illness

For many, the onset of mental illness occurs during mid- to late-adolescence, with the peak incidence of depression, substance use, anxiety disorders, and psychosis occurring during this time. Psychological autopsy reports, consisting of interviews with the deceased's intimates aimed at uncovering contributory factors in the suicide, have found that between 28 and 98 per cent of people who have died by suicide had a mental disorder or illness (Beautrais 1999:188).

In 1997, in an attempt to understand the diverse factors that contribute to an individual suicide, the Australian Bureau of Statistics (2000) began recording other diagnosed conditions noted on a suicide death certificate. Such reporting has confirmed that mental illness is formally associated with suicide in at least 18 per cent of deaths. With reports estimating that between 14 and 20 per cent of children and young people may be affected by mental illness (Commonwealth Department of Health and Aged Care 2000e:4), the likelihood of suicide and the need for suicide prevention strategies are clearly indicated for this group.

Negative stigma associated with the diagnosis of a mental illness and limited access to mental health services drastically reduce young people's opportunities to use preventative services. As a consequence, mental illness has been found to be associated with poor health outcomes (Commonwealth Department of Health and Aged Care 2000e; Mitchell 2000a; 2000b). Brent and colleagues (1988) report that 66 per cent of young people who complete suicide had never been interviewed by a mental health practitioner. This does not appear to be due to unwillingness to talk about their plans as 41 per cent of this group had disclosed their intention to a peer during the week preceding their death. A more likely explanation is lack of opportunity to access appropriate services.

People with mental illness and their families believe that discrimination may be a contributing factor to suicide risk, as mental illness potentially contributes to isolation, loneliness, unemployment and homelessness of those affected (Commonwealth Department of Health and Aged Care 2000c). While such evidence supports the notion that young people who have a mental illness are at elevated risk of suicide, it is equally important to note that most young people cope with, and adjust to, living with a mental illness (Commonwealth Department of Health and Aged Care 2000c).

History of previous attempts or deliberate self-harm

General agreement exists among researchers that having a previous history of deliberate self-harm or attempted suicide is indicative of high suicide risk. This type of history is present in up to half of all those who die or make further suicide attempts (Beautrais 1999; Commonwealth Department of Health and Aged Care 2000c). These young people remain at increased risk of suicide for years after their initial attempt (Wetzler, Asnis, Hyman, Virtue, Zimmerman & Rathus 1996).

Studies investigating suicidal behaviour in the total population of young people claim that between 5 and 10 per cent of representative samples of individuals report making attempts and around 25 per cent report suicidal ideation (Commonwealth Department of Health and Aged Care 2000c;

Graham et al. 2000). Such high levels of suicidal ideation are of concern. However, in the absence of other risk factors, ideation alone is not thought to be an independent risk factor (Beautrais 1999; Commonwealth Department of Health and Aged Care 2000a).

Attempted suicide with no other risk factors does not predict 'successful' suicide. Research in this area has encountered methodological problems (for example see Cantor et al. 1999; Graham et al. 2000). However, as Allen (2000:29) suggests, continuing to study those who attempt suicide does provide valuable insight into the phenomenon of suicide when as is currently the case as 'rigorous, unbiased study of the antecedents of "successful" suicide is impossible'. At present, psychological autopsy reports appear to be the only avenue open to investigate the deceased young person's life and likely risk factors that contribute to their death.

Male

Recent rises in male suicide, and especially suicide of young males, makes suicide in Australia a primarily male phenomenon, with a ratio of four young men dying to every one young woman (Mitchell 2000b). The number of female suicide deaths has remained fairly stable over the last century, therefore the recent increase in suicide deaths among young people is solely attributable to the rise in male deaths (Allen 2000).

Why men are more predisposed than women to suicide remains unknown. Allen (2000) suggests that males are currently more influenced by social forces than females. This is validated by fluctuating suicide rates that correspond with social disruption, with a peak during the Great Depression and the lowest point during the Second World War. However, the social disruption hypothesis does not adequately explain the steady climb in the male suicide rate over the last thirty years that gradually levelled out in the mid-1990s.

In the recent past, the disparity between male and female suicide death rates was thought to represent males tending to use more violent methods, which in turn were more successful. This position was reinforced by the significantly higher numbers of young women hospitalised for attempting suicide than young men. Recent laws tightening the control of firearms have resulted in the methods being used by males and females becoming more similar (Beautrais 1999). Cantor and his colleagues (1999) suggest that restricting access to one method may result in another readily accessible method being substituted. Therefore restricting access to means may not reduce overall suicide rates, only the methods individuals choose to engage. This accounts for the changes in the methods young men have used over in

the past with no overall reduction of fatalities with the tightening of guns laws (Cantor et al. 1999).

Rural and remote

The rate of youth suicide differs by geographical location and particularly between rural and urban residence. The highest total numbers of youth suicide occur in urban areas, however rural areas have a significantly higher rate of youth suicide per capita. Over a seven year period, 1986 to 1992, the Australian Bureau of Statistics (1994) reported a 50 per cent rise in rural suicide among young men from 24 per 100 000 to 38 per 100 000. During the same period urban young male suicide deaths rose only slightly from 21 to 25 per 100 000. However, this difference between urban and rural rates only holds true for young men. Young women present a similar and stable rate across geographic place of residence over this time.

The only 'convincingly demonstrated' reason for this difference between rural and urban rates, Cantor and his colleagues (1999:55) suggest, is the accessibility of firearms in rural areas. According to Beautrais (1999) however, the focus on firearms obscures the extent to which other factors may contribute, including rural migration, unemployment, medical service utilisation, socioeconomic status and resource deprivation. Furthermore, the individual impact of these factors, such as hopelessness, loss of self-worth

and intergenerational dependence on welfare are ignored when attention remains focussed on firearms. Some sub-groups in rural communities, such as young gay men, young people with a mental illness, and Aboriginal groups are at increased risk of suicide, these factors building on their belonging to groups already deemed at 'social risk' (Allen 2000; Capp, Deane & Lambert 2001; Green 1996).

Aboriginal or Torres Strait Islander background

Limited statistics make it difficult to determine the level of suicide among Indigenous populations in the past. However, suicide is believed to have been rare (Cantor et al. 1999). A rise in the rates of suicide among Indigenous peoples in Australia appears to begin around the 1970s, with a dramatic increase in suicide and other deaths in custody. These events lead to the Royal Commission into Aboriginal Deaths in Custody, which began its investigations in 1987 (Royal Commission into Aboriginal Deaths in Custody 1991). Since that time changes in recording methods and an increase of research among Aboriginal and Torres Strait Islander populations is beginning to provide a clearer picture on the size of the present suicide problem.

Estimates indicate suicide risk for Indigenous Australians are 40 times greater than the general Australian population (Commonwealth Department

of Health and Aged Care 2000b:34) and are possibly two to three times the non-Aboriginal rate of completed suicide (Tatz 1999). A recent Queensland report on suicide among young Indigenous people suggests that males aged 15 to 24 have an extremely high rate of suicide. This rate is 112.5 per 100 000 compared with the overall population rate of 30.9 per 100 000 (Cantor et al. 1999). Cantor and his colleagues (1999) surmise that although there is very limited data pertaining to youth suicide in Aboriginal and Torres Strait Islander populations, the rates among this age group are rising faster among non-Indigenous groups and leads to speculation that there is a gross over-representation of suicide deaths among Indigenous peoples.

Although Indigenous suicide remains poorly understood, there appear to be certain factors that make young Aboriginal men more susceptible to suicide than young women. Beautrais (1999) suggests these include identity confusion, along with problems with adjusting to urbanisation, unemployment, discrimination, accelerated cultural change, loss of family and kinship ties, and high rates of substance use and violence. Clearly, as Tatz (1999) notes, these unacceptably high rates demonstrate that the programs intended to 'help' Indigenous people such as housing, employment programs, land rights, schooling and health, are failing (Tatz 1999). New programs aimed at addressing these issues to prevent Aboriginal

youth suicide are currently being trialled in Western Australia and appear to be yielding promising early results (Westerman 2003).

Gay, lesbian, bisexual, or transgender

Research examining the association between sexuality and suicide has recently intensified, following considerable debate about a possible correlation between sexual orientation and suicide risk (see for example Beautrais 1999). A typical hypothesis is that same sex attracted young people are exposed to homophobic attitudes, prejudice and disadvantage that causes psychosocial difficulties and personal stresses, which can lead to suicidal behaviour (Beautrais 1999; Graham et al. 2000; Nicholas & Howard 1998; Russell & Joyner 2001; Waldo, Hesson-McInnis & D'Augelli 1998). Moreover, these young people appear to be exposed to additional risk factors (alcohol and other drugs, family discord and violence, for example), while often being victimised by their peers and becoming isolated (Anon. 1995; Nicholas & Howard 1998; Waldo, Hesson-McInnis & D'Augelli 1998).

Current research suggests that same sex attracted young people are at most risk for suicidal behaviour or ideation prior to and during the 'coming out' process, when sexuality is central to the individual's identity formation at a critical developmental stage (Cochran & Mays 2000; Nicholas & Howard 1998; Russell & Joyner 2001). Russell and Joyner (2001) reported recently on a

survey from the United States of America, in a nationally representative sample of more than 12 000 young people. Their results suggest that 7 per cent of this sample of young people reported same sex attraction, occurring slightly more often in males than females. Those who did report same sex attraction were significantly more likely to report suicidal ideation and were two times more likely to have attempted suicide.

No equivalent data has been located relating to young people in Australia. The North American results however, support previous speculation about the high levels of suicide risk among this group of young people (Green 1996; Kendall & Walker 1998; Nicholas & Howard 1998; Peterson, Leffert & Graham 1995; Waldo, Hesson-McInnis & D'Augelli 1998). This large scale study by Russell and Joyner (2001) has helped dispel past criticisms of methodological limitations in studies examining suicide risk among same sex attracted young people due to sample size, leading to better understanding of the influence of sexual identity on suicide and suicidal ideation in young people.

Of the suicide risk factors subjected to significant research, sexual identity is the only one that remains largely hidden, potentially masking the true numbers of young people experiencing sexuality related issues. This is

illustrated by the evidence that shows individuals may choose never to disclose their sexual orientation:

There is one difference that sets sexual minorities apart from other minorities – that is that we can be invisible, and are assumed to be part of the heterosexual majority until we blatantly and publicly declare otherwise. (Kendall & Walker 1998:220)

Information to date, notwithstanding methodological criticism and now buttressed by Russell and Joyner's (2001) data, shows a correlation between sexual orientation or attraction and suicidal behaviour. However, even though this group tends to have highly elevated suicide attempts, completed suicide statistics are generally unavailable (Beautrais 1999). Thus, further investigation is needed to determine whether this group exhibit suicidal behaviours only, or do die at greater rates (Nicholas & Howard 1998).

Individual adversity

A host of factors affect individuals differently, many of which increase separation between individuals and society, which may contribute to suicide risk. Such factors include feelings of hopelessness, loss of sense of self, and self-worth, drug and alcohol use, abuse, homelessness and unemployment. Less tangible issues include loss of hope, lost sense of meaning, cultural disintegration and anomie (Allen 2000). Adversity factors and lack of integration or connectedness to society has been correlated to completed

suicide. Eckersley and Dear (2002) surmise that the failure of Western societies to provide identity and attachments, while concurrently promoting unrealistic expectations of personal freedom and autonomy, has contributed to alienation of young people and increased suicide rates.

In short, suicide, suicidal attempts and suicidal ideation have primarily been examined from a risk perspective to date. Understanding life conditions and experiences that, in the absence of protective factors, make a young person vulnerable to, or at risk of, suicide is potentially helpful. A cautionary approach is essential to recognise that individuals may feature characteristics of more than one group or that risk group membership may be invisible for any one individual.

It is equally important to recognise the limitations of using a risk framework. For example, 'risk' may merely be a set of correlates for the purpose of understanding the phenomenon of suicide, yet not be associated with, or have limited potential to predict, which individuals die by suicide. Allen (2000) suggests because of the difficulties in aiming prevention strategies at risk groups, there is an urgent need to further examine predictors of individual suicides. Notwithstanding the need for a broader framework, one that encourages exploration and understanding of suicide as a social health

issue, and in the absence of reliable predictive factors, the risk framework provides the clearest picture of youth suicide demographics to date.

Suicide – who dies and where?

The World Health Organization collects suicide statistics for member countries providing suicide comparisons across some of the member nations. The data used for such comparisons however is close to a decade old and may no longer represent current trends. However, it does appear that countries with similar social, religious and cultural characteristics have similar suicide trends and rates (Cantor et al. 1999). For example, in a review of current literature on suicide comparisons, Cantor and his colleagues (1999) find that in relation to young people, Australia has one of the highest youth suicide rates in the world with similar countries such as New Zealand, Canada and North America having comparable rates.

The United Nations International Children's Emergency Fund (1996 cited in Cantor et al. 1999:36) ranks Australia ninth for incidence of male youth suicide per capita. For females, Australia ranks eleventh. With the exception of New Zealand, the other higher-ranking countries had all been subject to national political or social upheaval at the time of data collection. Absence of a common tool for nations to identify, collect and record suicide deaths,

limits the ability to analyse such data in a meaningful and comparable manner. As yet, there are no sound explanations about which features of these similar cultural and social characteristics are involved in elevated suicide rates among young people.

The Australian experience

In Australia, a death is determined as suicide when this verdict is handed down by the coroner. For this to happen the coroner must be 'satisfied "on the balance of probabilities" as to the manner and cause of death' (Cantor et al. 1999:11). Methods for reporting suicide vary between states, with the Australian Bureau of Statistics compiling the official national records. In keeping with other countries, the Australian Bureau of Statistics uses the International Classification for Diseases – 10th revision (World Health Organization 1992) for suicide and self-inflicted injury.

Although this common reporting system allows for some between state and territory comparison of suicide data, individual variation in coroners' opinions as to the cause of any one death makes the Australian system vulnerable to human error. For example, coroners may be reluctant to hand down a finding of suicide due to potential negative effects on families (Cantor et al. 1999). Thus, many researchers, including Cantor and his

colleagues (1999), postulate that the actual number of deaths attributable to suicide is considerably higher than the officially reported rate.

The most recent information available from the Australian Bureau of Statistics (2003) reports that the largest increase in suicide deaths over the 77-year report period (1921–1998) was in the 15 to 24 year age group, while the 25 to 29 year age group had the highest number of suicide deaths. Further, over this period, the percentage of all deaths attributed to suicide rose from 3.3 to 27 per cent for males and 1.3 to 16 per cent for females (Australian Bureau of Statistics 2003).

In examining causes of all deaths in the 15 to 24 year age group, 24 per cent are caused by suicide, equating to 19 per 100 000, which is the second most common cause of death for this age group (Australian Bureau of Statistics 2000). Of particular concern is the number of young men taking their own lives, the rate of which has tripled over the past 40 years (Commonwealth Department of Health and Aged Care 2000c:10).

The methods used to complete suicide have changed over the 77-year report period, which may reflect changes in legislation and availability of suicide implements. For males the current most frequent methods of suicide are firearms, hanging, carbon monoxide and poisoning. While for females

poisoning was the most common means until 1996, since then hanging has become more frequently used, followed by carbon monoxide and poisoning.

Responding to suicide among young people

Australia was one of the first countries to offer a nation-wide response to the growing suicide rate after the United Nations (1996) recommended this approach in the early 1990s. Evolving from the First National Mental Health Strategy and the National Health and Medical Research Council's report on options for suicide prevention, the National Youth Suicide Prevention Strategy (NYSPS) was developed in Australia. The aims of this strategy were to both reduce youth suicide and address suicidal behaviour and attempts in young people (Australian Institute of Family Studies 2000).

Since the end of the NYSPS's funded period (June 1999), an evaluation carried out by the Australian Institute of Family Studies (2000) reported that the NYSPS had achieved the goals of initiating prevention programs. However, it is still too early to determine the effect these early intervention programs may have on the official suicide rates.

Impact of suicide policy focus in Australia

During the 1990s, state, territory and federal governments in Australia made a concerted effort to stem the number of young people dying by suicide through the development of comprehensive youth suicide policies. The outcomes of these policies remain to be seen. Every life saved from the decision to suicide as a solution to the seemingly insurmountable problems experienced by a young person is a success, albeit difficult to measure.

A comprehensive literature review undertaken as part of the NYSPS, the *National Youth Suicide Prevention Strategy: Setting the evidence-based research agenda for Australia – A literature review (1999)* concluded that the impact of suicide remains an under-researched area that deserves priority (Commonwealth Department of Health and Aged Care 1999). While the human cost of suicide is difficult to measure, the financial cost is estimated to be in the millions of dollars each year (Cantor et al. 1999), with estimates that approximately 230 000 years of potential life were lost to suicide among 15 to 24 year olds in the decade to 1992 (Australian Bureau of Statistics 2003).

The primary focus of the research and policy directions outlined above has been on the identification of young people 'at risk' of suicide and the prevention of suicide among this group. Consistently in the literature researchers have produced a 'coherent account of the risk factors and life

processes that lead to suicidal behaviours' (Beautrais 1999:245). Yet, the limitations of this view need acknowledgement, particularly in relation to the use of this one dominant framework informing mental health prevention and treatment services. Such a view limits the examination and inclusion of social, cultural and historical factors implicated in suicide (Eckersley & Dear 2002; Rogers 2001). These areas need to be addressed in the suicide research to enable a broader understanding of suicide risk, behaviours, deaths and bereavement.

Furthermore, while this focus is critical to reducing the numbers of young people dying by suicide, it also draws attention away from others involved in the suicide death. Of particular note is the invisibility of the parents losing a young adult son or daughter to suicide. The next chapter begins the task of uncovering grief and bereavement reactions generally and then particularly in relation to suicide.