



The construction of youth suicide as a community issue within urban and regional Australia

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Abstract

There is a dilemma within the suicide prevention field about the extent to which suicide should be openly discussed as a community issue. Some fear provoking imitation while others think it is essential in order to improve awareness, understanding and appropriate responses to young people's distress. While youth suicide is widely recognised to be an important issue within Australian society, little research has been undertaken on the socio-cultural context that shapes how it is constructed. This article reports on the findings of research within an urban and a regional community in which samples of young people, adults and service providers were interviewed about how youth suicide was viewed as an issue. The study revealed how different rural and urban community identities were connected to suicide through the circulation of media reports, personal stories and the (mis)use of statistics. Youth suicide was constructed through the process of young people talking about it with peers, and adults talking with each other, in ways that often emphasised selfishness, individual failing and stereotyping of marginalised groups. In contrast, professionals largely drew upon notions of risk to identify particular groups. In conclusion, we argue that dominant constructions can have a negative effect on access to services, community mobilisation and support around the issue of youth suicide. There is value in considering how to create dialogue between adults and young people who might benefit from engaging with views other than those of their young friends and classmates. We also recommend a more careful appraisal of the literature on normalisation and imitation.

Keywords

suicide, youth suicide, community, qualitative research, rural mental health, media, stigma

Introduction

On a friends' level, yeah it is an issue, but on a wider level like in our town I think it is almost invisible, like it is not really talked about. (Chucky, 17, Regional)

It is not really talked about at all. It is too sensitive; people really don't like hearing about it. (Kyle, 16, Subcity)

These comments made by young people in our research highlight the complex social relations shaping the construction of youth suicide as an issue in two regional and urban communities. In this article we focus on how young people, adults and service providers responded when asked whether they thought youth suicide was an issue in their community. This approach aims to

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explore how everyday understandings of the issues surrounding suicide, risk and prevention were constructed within community contexts and were mediated by a range of social institutions (e.g., media, schools, family, peer networks) (Bennett, Coggan & Adams, 2003; Eckersley, Wierenga & Wyn, 2005; Hassan, 1995). In this sense, individual understandings of suicide do not simply arise from internalised beliefs or cognition, but rather are profoundly embedded within the culture and structure of communities (Philo, 1996).

Communities play an important role in the process of mediating or shaping individuals' everyday understandings about issues such as youth suicide (Fullagar, 2001). As Colucci (2006) recently argued, everyday cultures provide the context where young people and adults interpret and negotiate the meaning, or meaninglessness, of their lives. Researching community constructions of youth suicide also provides a connection to historically situated socio-cultural meanings about mental health and risk that circulate within contemporary neo-liberal societies (Busfield, 2001; Fullagar & Gattuso, 2002; Lupton, 1999).

Current suicide prevention policies (e.g., Commonwealth Department of Health and Aged Care, 1998; Commonwealth Department of Health and Ageing, 2000) adopt the language of community in aiming to develop capacity and contexts that in turn enable individual and collective resilience. However, little is understood about how community members interpret and mobilise particular understandings of suicide that may be supportive of, or counter to, policy directions. In addition, community identity is itself a highly contested notion that can also marginalise and stigmatise those who do not appear to fit with normalised values and identities (Everingham, 2001, 2003; Fullagar, 2003). The mental health literature has widely documented how the problem of stigma arises through negative constructions of 'mental health difference' that creates distance between the 'normal' rational self and the 'abnormal' irrational other (Barry, Doherty, Hope et al., 2000; Goffman, 1963; Joffe, 1999). Sociologists have argued for the concept of stigma to be broadened from the individual level to incorporate the social relations that inform

labelling, stereotyping, separation, status loss, discrimination and the exercise of power (Link & Phelan, 2001). This is particularly relevant for the study of community responses to individual suicides as they will be mediated by a range of socio-cultural forces that generate stigma (e.g., media constructions, parental beliefs and social position, professional discourses). Education, early intervention and prevention programs can be important means of dispelling many of the myths that blame and stigmatise young people for taking their own lives. Exposing the social relations that shape a young person's decision to suicide also helps shift understanding from the 'failings' of individuals (e.g., personality weakness, not coping or mental illness), to a focus on networks of support, community responses and the development of effective services to reduce suicide (Fullagar, 2005).

In our thematic exploration of how youth suicide was constructed as an issue in two communities we identify differences between the urban and rural participants and report on the language used to articulate and construct suicide as a community issue. We explore several key themes about the perceptions of youth suicide as an issue in the community. First, participant responses are discussed in light of the circulation of statistics and stories about suicide via informal community networks and media reports. Second, we discuss differences between the responses of young people, adults and service providers. Third, the effects of everyday constructions of youth suicide are identified in relation to the process of distancing youth suicide (and stigma) from oneself.

Method

The construction of youth suicide as an issue was explored through semi-structured interviews with 81 participants. The project was approved by both the University of Sydney and Charles Sturt University's Human Ethics Committees. All participants were provided with an information statement about the project which included contact details for youth support and suicide prevention counselling services. In this article we have used pseudonyms to protect the privacy of participants. The sample included 41 young people (20 rural, 21 urban, aged 15-24 years); 24 service providers, including teachers, school counsellors, sports coaches, and youth

and health workers (10 rural, 14 urban); and 16 adults, including parents and community leaders (10 rural, 6 urban). The urban community (known as Subcity) is an outer suburban area of an Australian city, while the rural community (known as Regional) includes hamlets, towns and a regional metropolitan area, the size of a small city. Subcity is a relatively affluent area when compared with the rest of Australia, with higher incomes and low unemployment, higher rates of homeownership and a lower than average population of young people (aged 15-24), many of whom live with their families (Australian Bureau of Statistics: ABS, 2001). Regional is a growing regional centre with a higher than average youth unemployment rate and slightly lower than average incomes (ABS, 2001).

These two communities were selected because both had established suicide prevention networks. The prevalence of suicide in these communities and reasons for the establishment of these networks are discussed further in the findings. Recruitment strategies were employed to select participants with different backgrounds regarding socio-economic status, employment, gender and geographic location, although the majority were of Anglo-European descent. Local media coverage, fliers, youth services officers, sports coaches, youth council representatives and personal contacts assisted with recruitment. Direct experience with suicide was not part of the selection criteria as we were interested in the general community context within which suicide occurs. Three young women in the rural sample who had suicide-related experience volunteered to participate, and they were exceptions.

All participants were asked (in a style appropriate to them as a young person, professional or adult) ten open-ended questions such as, Do you think youth suicide is an issue in your community? What do you think contributes to young people taking their own lives? And what is being done to reduce youth suicide in your community? In addition, four vignettes (Finch, 1987) that described a young person contemplating suicide were used in order to focus discussion around specific examples (details about the interview process and analysis of the vignette data can be found in Gilchrist, Howarth & Sullivan, 2007; and Gilchrist & Sullivan, 2006). All interviews were tape

recorded and transcribed, coded and thematically analysed with the assistance of NVivo software, according to the principles outlined in Minichiello, Sullivan, Greenwood and Axford (1999).

In many ways, Subcity and Regional are typical Australian communities. However, we make no claims about the extent to which the results of this study are generalisable. Rather, this research should be regarded as exploratory as it aims to develop a deeper understanding of the cultural context within which youth suicide occurs. We also acknowledge that the 'findings' from our research are interpreted and constructed through our position as adult researchers engaging with youth issues (see McLeod & Malone, 2000).

Findings and discussion

Constructions of suicide through statistics and stories

Carson: *I know that Subcity is the worst in the world.*

Interviewer: *How do you know that?*

Carson: *Just word of mouth, it gets around and you hear on radio and other places like that. They were just talking [about it] on Triple J [radio station] today, believe it or not. (Carson, 20, Subcity)*

It is definitely an issue because I live in a rural area and we become very aware when there is a suicide in our region. About two or three years ago a young man who was 19, and a neighbour, hung himself in the forest behind where we live. I didn't see him but we knew about that after it happened... People don't want to talk about it but you pick up things here and there. (Suzy, parent, Regional)

Carson's comment illustrates how youth suicide is constructed in relation to popular media representations of community issues in ways that are often alarmist, inaccurate and sensationalised. In contrast, Suzy speaks of her knowledge of suicide through snippets of conversations and vague references that occur in everyday conversations in rural community networks. A majority of urban participants believed that Subcity had a reputation for having a high youth suicide rate and therefore they considered it to be an issue in their community. Among the urban participants, it was young men who were more likely to highlight the reputation of Subcity, describing youth suicide as 'rampant', 'the highest' and 'the worst'. In contrast, only three of the ten young women mentioned this issue. Two young men

questioned whether Subcity's reputation for high youth suicide was warranted and supported by actual statistics; however, the rest believed that youth suicide was an important issue in their community because of media reports.

In contrast, the majority of rural participants were more likely to suggest that youth suicide was an issue in rural areas generally, rather than within their particular community, although some mention was made of smaller towns that had experienced several suicides. Interestingly, despite the research on the higher rates of suicide in rural areas, several rural participants viewed the city as having worse suicide problems through association with other problems like drugs. A handful of urban informants were unsure if youth suicide was an issue in their community. Even fewer rural participants thought that youth suicide was not an issue in their community. Compared to their urban counterparts, many more rural informants reported direct experience with suicide either in relation to people close to them or in relation to themselves.

While variation in suicide rates for rural and remote areas is acknowledged by a number of studies, findings of higher rates of male youth suicide are consistent for the region in which our research was conducted (e.g., Beautrais, 1999, 2000; Bourke, 2003; Cantor & Neulinger, 2000; Wilkinson & Gunnell, 2000). Available studies used data from the 1990s, before the suicide rate began to drop. Some authors suggest that gun control measures implemented in 1996 might have led to a drop in the suicide rate among young men, but this is questioned by others, particularly given the prominence of death by hanging among this group. No data are available to suggest that relative difference in urban-rural suicide among young men has changed in the past decade. In light of this literature our findings highlight how everyday understandings of suicide as an issue are shaped by particular sources of information that circulated within the historical context of these rural and urban communities.

An historical analysis of Subcity's youth suicide reputation points towards factors that shape the construction of community identity in terms of how community members see themselves and how they imagine others will see them as a

collective. In 1991, in response to Subcity's reputation for a high suicide rate, a needs analysis report looking into youth suicide in Subcity was carried out by the local health authority. The report found that the actual number of suicides in the area had been quite low, but was increasing, whereas other districts were plateauing or decreasing to the point where, in 1989, Subcity and its neighbouring district had the highest number of suicides within the greater metropolitan area (along with an inner-city district). From 1990 to 1995, the local newspaper ran eight stories related to youth suicide, most regarding recommendations of the needs analysis report. In 1996 alone there were eight features about youth suicide, two of them on the front page. These stories were precipitated by the deaths by suicide of five young men within a two-week period. After this, awareness of youth suicide was heightened and there were several stories of local members of parliament championing the issue. This culminated in one of them stating that Subcity had an average of two young people per week committing suicide, and that it had one of the highest rates of youth suicide in any area in Australia, which was among the highest rates in the world. This opinion was circulated in the local newspaper in December 1998. As a result of these events, the Subcity Suicide Safety Network was set up to co-ordinate various suicide prevention services and programs.

A closer examination reveals that Subcity did not have a youth suicide problem greater than most other areas and it was certainly less than in many rural communities of Australia (Stewart, Chipps & Sayer, 1996). When several suicides occur close together (in a cluster, as appears to have happened in 1996) it creates a perception of high rates that can be misleading and alarmist. Averaged out over a number of years, the overall rate for Subcity at the time was comparable to that of other communities, or even lower. For example, suicide for all persons in the Subcity local government area from 1979-1992 shows Subcity to be among the lowest in both the larger metropolitan area and the state (Stewart et al., 1996). We keep in mind the Australian Bureau of Statistics caution about reporting annual suicide for smaller states and territories, which leads to the practice of pooling data over a number of years (Auseinet, 2005).

This issue demonstrates the impact that rate statistics of low incidence events (such as suicide) can have when reported for small population bases such as a local community, and shows the enduring nature of reputation and how slow it is to change. As mentioned earlier, suicide rates for young men at the national level have dropped markedly in the past decade. In the state of which Subcity is a part, youth suicide rates dropped by over one-half; in the case of males from 33.2 to 12.3 deaths per 100,000 in 1997 and 2004 respectively. In 2004, there were 58 suicides by males and 17 by females aged 15-24 years across the whole state of which Subcity is part (ABS, 2000, 2004, 2005; Robinson, 2006). The situation is less sanguine in regard to suicide attempts and gender differences. The rate of hospital attendance following a suicide attempt has increased dramatically for young women over the past decade and increased slightly for young men, from 285 to 485 per 100,000 for females and 158 to 197 per 100,000 for males between the ages of 15-24 years between 1996-7 and 2004-5 (Robinson, 2006). In relation to Subcity more recent statistics for the area are not available but there is little reason to believe that suicide rates for this community differ from national trends.

Within the rural community a suicide prevention network, comprised of local professionals and interested individuals, was formed in 1992. In addition, a specially funded suicide prevention community development project was established in 1997 to work intensively for two years to dispel myths, raise awareness about risk factors and engage young people in help-seeking behaviour through a range of initiatives. It continued for another two years with much reduced funding to develop sustainable partnerships with key stakeholders in the community. This project began with a needs analysis within the area health service to identify deaths, hospital admission rates and estimates of youth suicide attempts. Thereafter, youth suicide was 'mapped' by geographic region, and was found to be higher in more isolated rural areas. The local newspaper reported that the area had a high youth suicide rate. Media analysis shows that newspapers did not report individual suicides in smaller towns, but sensationalised the issue in larger towns. The general trend in reporting produced negative and stigmatising

stereotypes of mental illness, homosexuality and youth (Health Promotion Business Unit, 1998, 2000). Once established, the enduring nature of these views is remarkable, particularly when there is no new 'evidence' to refute them. Indeed the concerns may be warranted to that extent that youth suicide attempts appear to be increasing, even if actual suicides have declined.

Our findings showed that the overall community reputation for suicide was much less clearly established among the rural participants than the urban participants (although the same cannot be said for experience of suicide either personally or through friends and family). This may be related to the ways in which community is defined geographically and socially within a broad regional area as distinct from a suburban area of a city. There was far less frequent reference to suicide rates by rural young people than among the urban participants. When they were cited, it was usually by university students who had studied the issue.

Different perspectives on the issue of youth suicide

In this section, we examine the themes arising out of the different perspectives that young people, adults and service providers articulated about the nature of youth suicide as a community issue.

Young people

It always starts out in a gossipy way, and the story always develops more dramatically as it gets passed down, and then you hear it from someone who actually knew the person, or in the media, and you put all the pieces together. (Renee, 22, Subcity)

Young people drew upon their experience and stories related to suicide as a major source of knowledge that influenced whether they felt it was an issue in their community. Among the urban participants only one young man spoke of attempting suicide (he identified as gay) and two of the young women spoke of friends or family that had attempted or died by suicide. In contrast, among the rural participants there were five young women who had attempted suicide previously, three had close friends/family who had attempted or died by suicide, and two knew of more distant deaths. With the rural young men, one had thought about suicide seriously, five knew friends/family that had attempted or died by suicide, and four knew of distant stories.

Although there appeared to be a less established reputation of suicide in the rural community, these young people had a greater level of exposure to suicide related experiences within their immediate communities. There was also far more recognition of suicide as an issue that affected young women, in contrast to the urban participants who tended to reiterate dominant constructions of suicide as a problem for young men. (Given that three young women who attempted suicide volunteered for the rural study, this could be a sampling artefact.) Only one young woman (15 years old) did not think youth suicide was an issue among her adolescent peers. She had recently moved to live in a small community but was unaware that it had experienced several male youth suicides over the last six years. The four young, rural men with the least direct experience also thought that youth suicide was not a particular issue in their local communities or peer networks because they had not 'seen' much of it. They were also more likely to view suicide less compassionately, as a 'selfish' or irresponsible act. Among these respondents with little direct experience, suicide was not an issue they felt affected them or their friends. For the majority of rural participants, suicide had become recognised as an issue because of the close proximity to their own suicidal behaviour or that of others within their communities (as well as media reports in larger towns). However, while there were a range of sympathetic responses that identified the reasons contributing to young people feeling suicidal (e.g., relationship breakdown, family difficulties, high expectations, poverty), there were also many responses that individualised these problems as personal failings and sources of social stigma.

In contrast, among the urban participants, stories of a 'friend of a friend' who had suicided were more commonly reported. In addition, the stories relayed by male and female participants nearly always involved young men taking their lives. The source of the young men's information about suicide was generally through informal networks. Some had heard about the issue from teachers, but not as part of the curriculum. This supports previous research that indicates how young men tend to seek help through friends and family rather than via 'official' channels (Boldero & Fallon, 1995). Although many of the

young people knew of Subcity's reputation for high youth suicide and believed it to be a problem, they could at times seem dispassionate about the subject, describing suicide predominantly as a 'selfish act'. The lack of direct personal experience may contribute to a lack of understanding about youth suicide, perhaps through the overt reliance on gossip, innuendo and speculation about the individual failings and circumstances surrounding a young person's death. In this respect, the disjunction between knowledge about an issue and attitudes towards it, which has often been observed in the health promotion literature, was also evident in this study (Gilchrist, Sullivan & Heard, 1997; Kalafat & Elias, 1995).

Adults

Half of the Subcity parents interviewed considered the community to have a high suicide rate compared to other areas of the country. Two reported reading about it in the local newspaper, and one parent had attended a talk by a local MP at his Rotary Club a few years ago. The other three parents all speculated that it may be a problem because 'it seems fairly common' (Judy, parent, Subcity). None of the six parents personally knew anyone who had suicided. While they were less likely than the young people to describe friends of friends (or the children of friends) whose suicide they had heard about, some still used anecdotal evidence to support their suggestion that youth suicide was an issue in their community. All parents but one, regardless of whether they thought it was an issue particular to their community, expressed concern about youth suicide. However, suicide was articulated as an issue that was rather distant from their personal concerns that fortunately had (or would) not directly affect them. As one mother put it, 'luckily my children were both popular' (Judy, parent, Subcity). Within the largely middle class region, stigmatising associations were often made between suicide and the perceived social status of lower income areas, drug problems and youth cultures connected to the beach (Felicity, parent, Subcity).

Among the rural participants, the ten adults all identified youth suicide as an issue that required some kind of action by local councils, youth services and community members generally.

Most adults did not cite statistics, but half had known of young people who had attempted or died by suicide (including an attempt by one participant's daughter), while the other half knew stories about the children of friends of friends. There was recognition that youth suicide was an issue but not one that could be solved easily or quickly by community members or professionals. As Sally said:

An issue to me is something you can solve and I don't think you can solve youth suicide by just saying 'If you do this or look for these signs...' (Sally, parent, Regional)

Suzy (parent, Regional) spoke about the paradox of living in rural communities where young people can be both highly visible (seen by many others in everyday life) and invisible (distress remains unrecognised) within networks that can both connect and isolate. Talking about problems could be a source of stigma associated with personal failing and not fitting in with dominant norms. Suzy said:

You don't talk about your troubles in a rural community. You play sport together, you go to church together, you see each other down the main street... There seems to be a real lack of will on the part of the movers and shakers in the community to stand up behind their young people. You either make it or you are written off as a piece of trash.

Jim (grandparent, Regional) also made the point that people are 'reluctant to get involved' in the problems of others. Parents identified the need for more community based intervention services, as well as youth friendly spaces and activities that would be inclusive of marginalised young people, particularly in small towns. These responses are also identified in other Australian research that notes how certain aspects of rural community life impact in negative and positive ways on mental health (Wainer & Chesters, 2000). While suicide was clearly identified as a community issue, there were different notions of community employed in explaining young people's connection and disconnection from their peers, professionals, families and broader networks. In contrast, the urban adults drew upon a much broader notion of the local community as comprised of different socio-spatial areas (poor areas, beaches with drug use) that were associated with suicide.

Service providers

Four of the service providers in Subcity felt that while the community may have previously deserved its reputation for a high incidence of youth suicide, this was no longer the case. Ken (youth minister, Subcity) said, 'A few years ago it was like an epidemic'. These service providers spoke of their 'battle' against youth suicide, as they saw it 'from the frontline', and felt that they were winning. Each of the service providers had worked in different capacities and to different degrees for over 20 years to reduce youth suicide and they all felt that the perceived drop in the suicide rate was due to an increased awareness of suicide in their community and particularly in schools. Conducting suicide prevention programs was not, however, easily undertaken within institutional settings where there were 'contagion' fears about increased awareness of the issue. Pam (counsellor, Subcity) talked about how she had to change the focus of her program away from young people themselves to parents:

We had some sponsorship to go into the schools to give an educational program [about youth suicide] to the students. That was not accepted [by the school], so we watered it down a little bit and said we would go and talk to parents. That was accepted a bit more. Their policy is that if you talk about suicide it might happen.

While unfamiliar with the latest suicide statistics, these informants had apparently made accurate assessments about the incidence of youth suicide. They suggested that the increased awareness about youth suicide as a result of similar initiatives caused it to be less of a community issue. This opinion is difficult to confirm according to research on the effectiveness of prevention programs and socio-cultural changes more broadly (Beautrais, 1999). However, recent research by Morrell, Page and Taylor (2007) suggests that suicide prevention programs may have been influential in reducing the youth suicide rate. It is unclear whether the rate of unsuccessful suicide attempts (Robinson, 2006) is rising or if such events are receiving more attention. Whatever the case, it is of concern that youth distress remains high.

A few service providers showed some familiarity with statistical information, which they used to construct youth suicide in relation to certain 'at risk' groups. For example, Melissa (youth

services co-ordinator, Subcity) commented on how youth suicide was an issue that primarily affected young men:

In this area the media has picked up on youth suicide as a big issue, but the statistics, I think, show that it is a men's issue.

This gendered construction of suicide risk makes it recognisable as an issue for men, but it remains under-acknowledged as an issue for young women despite research that has identified the high number of attempts that young women make and their higher rates of depression (Commonwealth Department of Health and Ageing 2000; Robinson, 2006).

Not all of the service providers believed that Subcity's reputation was justified. In particular, three of the fourteen different service providers interviewed were quick to point out that Subcity did not have more of a youth suicide problem than any other area and did not deserve its reputation in this regard. Surprisingly, not all of the service providers we interviewed were concerned about, or even aware of, the issue of youth suicide. For example, three service providers who work closely with young people (e.g., sports' coaches and activity organisers) did not know if youth suicide was an issue in their community. While they did not have regular dealings with suicidal young people as did service providers in mental health, it is likely that they came across young people who had considered suicide. This lack of awareness reflects the need for further staff training about suicide in the youth and recreation sectors, as they are identified as important 'partner' agencies in suicide prevention policies.

Among the rural participants, the knowledge that service providers had about youth suicide ranged enormously but all ten agreed that it was a significant issue that needed to be addressed in an ongoing way. As Elizabeth (grief counsellor, Regional) says:

...because of all the work that has been done there are a lot more people who are aware of the deaths and that it is a complex problem, not just a simplistic description of 'those stupid kids'. There is a lot more work to be done. Like immunisation, you have to keep re-vaccinating the community.

Most service providers knew about the issue because of local suicide prevention initiatives or through their own professional experiences (and

in one case, a youth worker spoke through personal experience). Yet, a number held onto popular myths about suicide, for example, 'those who talk about it are unlikely to do it'. Few service providers cited statistics or research directly, and some mentioned the problematic reliance on suicide rates within smaller communities. As Peter (health service manager, Regional) said:

It's a fairly significant issue for rural people. I haven't got any facts but it is something we are concerned about as an organisation... we are such a small community it is hard to say what happens here. If we have one youth suicide in a given year it would make us look extremely abnormal from the statistical point of view.

Professionals with direct responsibility for addressing the issue spoke about their frustrations with the lack of knowledge about suicide among youth workers. Connected to this were misconceptions arising from the use of suicide statistics to determine risk, which affected how professionals constructed the issue. For example, Xena (health promotion worker, Regional) spoke about how professionals misconstrued suicide as a risk only for people who are economically disadvantaged:

I have health service managers say to me 'it's only a low socio-economic issue', so we put that in the educational material to acknowledge that yeah, it is a huge factor but you can't define community by what you earn each week. It is interesting the perception of who is at risk in the community.

These findings raise a critical question about how people are identified as at risk and how community is defined within suicide prevention policies as largely a benign or positive force for mental health. Idealised constructions of community effectively ignore the stigmatising power relations that exclude certain kinds of young people in relation to mental health, gender, ethnicity, sexual orientation and socio-economic status (Malone, 2000; Wyn & White, 1997).

Stigma and the distancing of suicide

The construction of suicide risk in relation to the social differences within communities points to the stigmatising process of othering that blames the person for individual (not coping) and social circumstances (poverty). Stigma involves a distancing of the self from the social-emotional

lives of others who are perceived to have lower social status such as 'poor people', 'losers', or those from 'bad families' (Joffe, 1999; Link & Phelan, 2001). Among the urban participants, several people identified particular areas within Subcity that may have a youth suicide problem, rather than Subcity as a whole. There were two distinct areas that these informants felt were 'high risk'. First, there were several parents who named the most affluent suburbs as risky because they felt that the pressure to succeed and to have all the right commodities would be much greater in this area. These responses tended to be more sympathetic and the social circumstances of middle class young people were less stigmatised. More often parents and young people mentioned the areas in Subcity that were less affluent, more isolated and further from large shopping centres and services, where new, less expensive housing is located. One young man believed that while youth suicide was an important issue, it was less of a problem in his middle-class community than elsewhere, especially compared with 'a lot of the dodgier suburbs' (Murray, 21). In particular he cited a particular inner-city suburb (with a high Aboriginal population, a low socio-demographic profile and a high crime rate) as having a high rate of youth suicide, which suggests that he viewed youth suicide risk as an issue associated with stigmatised socially disadvantaged areas. While social disadvantage is a risk factor for youth suicide (Beautrais, 1999), Murray associated suicide risk with a morally suspect reputation and particular social groups that are defined as less deserving in relation to dominant middle class values. One young woman was speaking from experience (the five people who she knew who had suicided had all come from the same suburb in one of these areas). Others did not give reasons for their views, although Gary (16, Subcity) referred to the people in these areas as 'povos' (i.e., poor). Another referred to the area's 'drug problem'.

Matthew (18, Subcity) commented on 'poor people' and how they 'don't... have the will to break out of the circle and change it... they're not strong enough... they're like not willing, sort of thing'. Ending one's life through suicide was frequently constructed through morally loaded terms such as 'selfish' or 'an easy way out'. In this way the social or community context is

explained in terms of the individual's characteristics. The suicidal individual is stigmatised through stereotyped notions of weakness and lack of resilience, and they are assigned responsibility for the social circumstances that give rise to suicide. Comments about social inequities often did not reflect a sense of understanding or sympathy for those suicidal young people experiencing disadvantage. Harsh, judgmental comments of this type about high-risk life contexts were more often made by urban than rural young people, and male rather than female participants. This raises the issue of how to engender greater empathy and understanding of the life situations of diverse young people among their peers, many of whom are well versed in the language of class distinction, gender hierarchy and social status. Our findings also suggest that the language of suicide risk often dovetailed with stigmatised constructions of social difference within communities. This raises a complex issue of how policies and education programs that mobilise the language of suicide risk in prevention and early intervention efforts might also be reinforcing social stereotypes and stigmatising certain identities (Fullagar, 2005; Joffe, 1999).

The research findings point to how certain constructions of suicide as an issue can reiterate a division between 'normal or average' people who don't suicide, and those who are positioned as 'abnormal' due to their perceived social and psychological difference. This process of othering could prevent young people from discussing suicidal ideation or distress for fear of being stigmatised as socially 'abnormal' or known as having 'emotional or mental health problems'. Interestingly, the mention of the wealthier suburbs shows that there was critical awareness among some participants that there are also pressures on young people arising out of middle-class expectations about individual success, competitiveness and normalised achievement (Everingham, 2003). As Kyle (a 16 year old gay youth who had previously attempted suicide after 'coming out' in Subcity) said, 'You may have a lot, but you are not [guaranteed to be] happy'. Few informants in this project knew that while social disadvantage is a risk factor, almost all adverse events in young people's lives have been linked to

increased risk for suicide or suicidal behaviour, as have family problems and many individual characteristics (Commonwealth Department of Health and Aged Care, 1998). Hence, the notion of a 'normal' life that is implicitly defined against a construction of the suicidal other as abnormal, does not necessarily make a young person immune to suicide.

Conclusion

The comments by young people in this study suggest that while they see suicide as an issue that is largely taboo, they do discuss it among themselves and they hear about it from a range of sources such as teachers, media reports or gossip. Suicide was constructed through a language of speculation about why and how it happened; hence there are wide ranging views about who is to blame (e.g., family, relationships or individual failings) and what should be done to prevent it. Many young people felt they did not know enough about the subject and expressed a desire to have the issues surrounding youth suicide discussed more openly.

Service providers in our study were often at odds about the need to raise community awareness of the issue on the one hand, but on the other, not to normalise suicide by talking about it. Within the suicide literature there are debates about whether public discussion (e.g., through school awareness programs) and media reports about suicide may normalise this behaviour as an option for young people in times of despair (Etzersdorfer & Sonneck, 1998; Goldney 1989; Hassan 1995; Phillips, Lesyna & Paigh 1992; Pirkis & Blood, 2001a, 2001b; Schmidtke & Hafner 1988; Shaffer, Garland, Vieland et al., 1991; Sullivan, 2007). These tensions suggest that it is simplistic to attempt to prevent discussion of suicide (for fear of imitation), as young people talk about it anyway. The absence of discussion merely serves to reinforce the stigma and taboo related to 'mental health problems', which in turn prevents young people talking about suicidal feelings (Philo, 1996). This raises the vexed issue of how suicide might become part of public and professional discourse where emotional difficulties, existential dilemmas, fears about life and understanding of death can be safely explored in a way that is respectful of young people's desire for knowledge and understanding of these issues.

We agree with Barry et al. (2000) about the need for further research into the social relations that shape everyday understanding. They state that:

...awareness raising and destigmatisation have a significant role to play in mental health promotion programmes. There are few reports in the literature of mental health awareness and promotion programmes being implemented at the local community level. Such programmes require in-depth studies to examine socially shared beliefs, how they arise and change over time, how they vary between social groups, and how they relate to mental health behaviour. (Barry et al., 2000, p.295)

A number of themes emerged from our interviews with young people, professionals and adult community members. First, young people know about youth suicide, talk about youth suicide and are exposed to youth suicide. The informal and limited nature of their exposure to this topic has implications for how they will view suicide as an option in times of stress and difficulty, and how others will see and stigmatise them. If they view suicidal feelings as taboo, they may be reticent to seek help when feeling depressed or suicidal themselves. They may also be less likely to intervene if a friend is distressed.

Second, service providers are divided on the subject of whether youth suicide should be discussed or addressed openly. While there are conflicting views on this topic, it seems apparent, at least from our research, that to refrain from addressing youth suicide in structured contexts does little to stop young people from being exposed to it. As the comments by rural young people indicate, many are grappling with their own and their friends' suicide-related experiences. While the possibility of normalising or glamorising suicide cannot be ruled out, convincing evidence that this occurs has yet to be provided and the mechanisms by which it occurs are poorly understood and often simplified within the research literature (Sullivan, 2007).

Finally, those parents and young people who view youth suicide as distant from themselves tend not to see it as problem that may affect their lives or those of others close to them. Awareness of suicide as an issue does not necessarily mean that people see that it has relevance to them. A partial explanation of this may be a lack of

understanding about the complex socio-cultural reasons that contribute to individual youth suicides, and stereotyped views of marginalised 'at risk' groups. The influence of statistics and stories within media reports work to construct community reputations and influence everyday understandings of community members and professionals who support young people. In addition, the mobilisation of a whole-of-community approach in suicide prevention policy requires further critical analysis in relation to the norms and exclusionary practices that stigmatise particular young people and the expression of emotional issues.

In conclusion, we are concerned that silence due to the fear of provoking imitation has a negative effect on services, community mobilisation and support around the issue, and on the provision of adult perspectives to young people who might benefit from hearing views other than those of their young friends and classmates. By extension, not to engage in more *critical* discussion about the socio-cultural context of suicide may well serve to perpetuate stigma through stereotyped notions of individual failing or broader social risk factors.

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