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Abstract

Drawing upon insights from the governmentality literature and risk theory this article examines the implications of the rise of particular rationalities of suicide risk for professional help giving-seeking relations with young people. It examines the discourses of professionals, young people and adults who participated in a three year qualitative research project focused on youth suicide prevention within a rural Australian community. The conduct of helping professionals and young people themselves is shaped by policy discourses that emphasis the calculation and management of suicide in terms of 'clinical risk' (Weir, 1996). However, this way of constructing risk generates contradictions and paradoxes for both professionals and young people with respect to the risks associated with the experience of seeking-giving help. Professionals identified issues of empathic failure and the emotional distance that risk discourses create. Young people mobilised a discourse of risk affect that emphasised the dynamics of shame and fears about confidentiality. The reliance on psy-experts to manage individual risk also raises the issue of community members and families losing confidence in dealing with young peoples' everyday emotional dilemmas. The issue of how professionals are implicated in the government of young people's emotional lives (and deaths) creates a pressing need for further critical debate about the effects of dominant rationalities of mental health risk.

In Australia youth suicide and self-harm have been identified as key issues within contemporary health policy and within the life of rural communities where young men are dying at higher rates than urban areas and young women are increasingly hospitalised for their attempts (Burke, 2003, Hassan, 1995). In response to Australia's relatively high youth suicide rate within the Western world suicide prevention policies have been developed to focus on population and individual 'risk factors' (previous suicide attempts, mental health problems, social isolation etc) that contribute to young people taking their own lives. Policies have also identified 'protective factors' (social connectedness, problem solving skills, available mental health services) that encourage young people to seek help from professionals and within communities. Through the dissemination of such policies the language of suicide risk has entered into the professional discourses of different kinds of psy-expertise (clinical psychology, psychiatry, mental health workers, youth counsellors etc.). Drawing upon insights from the governmentality literature and risk theory this article examines the implications of the rise of particular rationalities of suicide risk for professional help giving-seeking relations with young people. It explores the discourses of professionals, young people and adults who participated in a three year qualitative research project focused on youth suicide prevention within a regional Australian community.

The promotion of help seeking practices has become a key governmental strategy tied to the risk reducing imperatives of current Australian suicide prevention policy (*Living is for Everyone*, Commonwealth Department of Health and Aged Care, 2000a,b). Young people are urged to ring helpline phone numbers, use Internet sites to seek information and support, talk with mental health professionals, be aware of warning signs and engage in school based mental health promotion programs. Professionals such as psychologists, teachers, counsellors, mental health and youth workers, importantly mediate these policies aimed at increasing young peoples' help-seeking behaviours within communities. Young people's decisions about seeking or refusing help, in managing their emotional distress and wellbeing, are often produced in relation to their knowledge of, and engagement with, different professional relations and forms of expertise. From a governmentality perspective we can see how professionals are implicated in power relations that govern 'at a distance' the subjectivities of young people via discourses about risk and help-seeking that inform their own help giving practices (Tait, 2000). For example, through the dissemination of policy, professionals become increasingly aware of 'at risk' populations (Aboriginal, same-sex attracted, rural men etc) and individualised warning signs (depressed mood, isolation etc) within therapeutic practice. In this way professional discourses about risk work to subtly regulate the 'conduct of young peoples' conduct' (Gordon, 1991, Foucault, 1991). Improving the help seeking conduct of young people is also linked to broader neo-liberal discourses that work to shape the understanding and management of emotional subjectivity. For example, the language of increased self-esteem, greater locus of control and self-responsibility are linked to ideals of adult identity as active and resilient with a view of life as an 'enterprise' of self improvement (Rose, 1990, 1999).

With the demise of the welfare state Dean (1999b) argues that the conduct of professional life is also increasing regulated by neo-liberal concerns about greater accountability, performance based management, evidenced based practice and outcome focused interventions that quantify and calculate helping relations. With the emergence of suicide risk discourses, professionals are often positioned within paradoxical and contradictory relations with the young people they are seeking to help. For example, if a young person is talking about suicide then risk must be calculated and assessed in order for professionals to then prioritise a young person's 'safety' that may override their wishes for confidentiality

etc. (New South Wales Health, 1999, CDHAC, 2000a). There are moral, legal and professional sanctions that arise if suicide risk is ignored or not rationally 'managed' (and a young person dies or makes an attempt on their life). Within suicide prevention research there has been little discussion of the implications of particular risk discourses in relation to how young people and professionals construct practices of help seeking and help giving. Exploring these questions may assist our understanding of what prevents young people, particularly in rural communities, accessing help and support when they need it most.

Such questions work to problematise the rational/irrational opposition informing help-seeking discourses that position young people in emotional distress as the 'source' of and 'solution' to suicide risk. The risk of suicide is identified as greater for those young people with 'mental health problems' that often start in late adolescence and this works to position them as 'irrational' actors. Yet, at the same time young people are positioned individually as 'rational' actors whose help-seeking behaviour can be modified through policies that are taken up by professional discourses. This paradox within youth suicide prevention policies works to *universalise* young people as an 'at risk' population by *individualising* the experience of suicide risk in relation to behaviour and circumstance (depressed, recently bereaved, drug or alcohol problems, unemployed, histories of abuse and violence etc) (CDHAC 2000b, p20). Professionals are positioned as individual risk managers within a broader public health policy that locates risky identities (indigenous, rural men, same-sex attracted) clearly within the social and population domain. Suicide risk is in fact constituted through a close connection between the calculative rationality of epidemiological risk (population morbidity and mortality rates) with clinical risk discourses that diagnose behavioural, personality and other individualised elements (Dean, 1999b, Petersen and Lupton, 1997, Weir, 1996). Yet, the effect of such connections is to reinforce an individualised response to suicide risk that may in fact de-emphasise the unique professional and community relationships required to deal with an individual in distress.

While current policy (CDHAC 2000a, NSW Health, 1999) mentions the cultural context of emotional wellbeing it draws heavily upon the language, and hence, logic of mental health discourses that emphasise the rational management of suicide risk through the calculation of risk and protective factors. For example, 'there is a generally held belief that suicide does not occur in those who have good mental health, good interpersonal relationships, and family and community support. It follows that if there are enough protective factors to offset risk factors, and people with illness can be returned to health, vulnerability to suicidal behaviours may be reduced' (CDHAC 2000a, p.28). Within this construction of suicide and mental health young people's emotional distress and dilemmas of subjectivity become static, quantified 'categories' of risk rather than social and cultural processes (Rose, 1998). As Williams (2001) argues, mental health as the commonly employed discourse concerning inner subjectivity, is actually premised upon a mind-body opposition that suppresses the cultural recognition of our embodied affective or emotional life (see also Busfield, 2001). In this sense the calculative rationalities informing contemporary discourses of 'suicide risk' may indeed severely limit the way young people's emotional lives and affective relations are understood in suicide prevention practices. In addition, Holdsworth and Dodgson (2003) also identify epidemiological risk as highly problematic for professionals as it fails to acknowledge the complexity of the clinical reasoning process involved in assessing suicidal risk for those with or without mental health 'disorders'.

Whether we understand our contemporary culture and social world in terms of an emergent 'risk society' (Beck, 1992) or in a less unified sense as governed through multiple risk

discourses and dynamic relationships (Lupton, 1999), there are important implications for understanding how different kinds of psy-expertise engage with the emotional or affective formation of young people's identities. What are the consequences of urging professionals to privilege particular kinds of expertise (epidemiological and clinical risk calculations of disorder and pathology) at the expense of other knowledge relations (experiential, critical reflexivity, critical empathy)? Indeed how might this emphasis on 'emotional risk management' mitigate against establishing effective help giving and help seeking behaviours for and with young people?

Affect, Risk and Rurality

Policy discourses work to constitute particular 'risky' youth identities through tautologies of suicide risk that fail to identify emotional complexity. For example, rurality is associated with increased suicide risk because it creates the conditions for risky behaviours through limited opportunities and services.

For young people in rural areas, there is often a profound mismatch between idealised images of life in the bush, glamorised images of popular youth culture and the realities of their own lives. This has the potential to create feelings of frustration or resentment, which may be associated with mental health problems or risk-taking and self-harming behaviours. Frequently the local area offers limited opportunities in education, training and employment, or recreation and leisure, with similarly limited health services. (CDHAC, 1999b, p.22).

In this way risk discourses fail to acknowledge the social-emotional dynamics of shame that may govern the subjectivities of, for example, indigenous or gay rural youth within the context of white, heterosexist norms and uncertain rural economies (Fullagar, 2003, Burke and Lockie 2001, Tait 2000, Dean 1999, Rose 1999). Tatz (1999, p.195) makes a poignant comment about the listing of Aboriginality as a risk factor for suicide '...it sits badly to have a national suicide body, a key government agency and a dedicated church mission listing race as an inherent cause of its own self-destruction'. In relation to Aboriginal suicide he also makes a similar criticism of how mental health is too easily deployed in pathologising descriptions of the inner lives of indigenous Australians, who tend not to use the term itself. The emphasis on identifying risk factors that contribute to suicide may provide a useful overview of population patterns. However, it tends to ignore the complex power-knowledge relations that govern the way particular young people do or do not seek help within rural or urban contexts. Power relations that shape the way that young people are socially positioned and come to feel about themselves are rendered invisible through risk discourses that reify identity and mobilise mental health discourses to explain suicide.

Suicide is a decision associated with the 'irrational' self, but it could perhaps be better understood as shaped by the forces of affect and the cultural conventions that produce our emotional or affective selves (Lupton, 1998, Tomkins, 1995). The young self is negotiating the process of becoming adult and hence the rules that govern the formation of 'responsible selfhood' as it is articulated through the gendered discourses and institutions of neo-liberalism (Wyn, 2000, Dean, 1999). Hence, an exploration of the discourses that young people use to talk about what stops them and their peers from seeking help provides us with an insight into the cultural logics or rationalities that govern the affective dimension of subjectivity. This may also assist professionals and policy makers to think about the effects of dominant discourses that embed themselves within new regimes of truth about how to deal with a young person at risk of suicide. In this way a reflexive approach to

suicide prevention (health promotion, clinical practice, community development work) is advocated as it emphasises the importance of critically examining the effects of professional practices and policy discourses without recourse to singular methods or moral discourses of blame (Taylor and White, 2000).

The Research Project

The project was conducted within a rural area (pseudonym 'Bordertown') of Australia that crosses two eastern States as part of a large qualitative study investigating the cultural context of youth suicide within urban and regional communities (Fullagar, 2001).

Bordertown is a growing regional city with a diversity of smaller outlying towns and has had active suicide prevention programs and networks for a number of years. In-depth interviews were conducted with forty rural participants (service providers, young people, adults) to examine how youth suicide was made sense of and how it might be addressed in terms of prevention. The ten service providers interviewed included youth workers, counsellors, health promotion workers, health service managers and teachers, with slightly more women than men. The ten adult participants included parents, grandparents, sports coaches, scout leaders with equal numbers of men and women. The ten young men and ten young women recruited through local contacts, snowballing, youth services and media publicity were not necessarily known to be 'at risk' or have any previous suicide experience. However, three young women approached the researchers to be participants in the study and each of them had suicide related experiences.

A range of recruitment strategies were employed to select participants with different socio-economic location, employment status, gender, geographic and ages (fifteen to twenty-four), although the majority were of Anglo-European descent. Local media coverage, fliers, hanging out in youth spaces, contacting youth workers, sports coaches, youth council representatives and personal contacts were used to recruit participants. Each participant was asked ten open ended questions relating to the reasons behind suicide, risk, knowledge of prevention, barriers to seeking help and suggestions for change. In addition we utilised at least one of four different vignettes that described a young person contemplating suicide in order to focus discussion around specific examples (Finch, 1987).

Within this rural cohort of young people there were five young women who had attempted suicide previously, three had close friends/family who had died or attempted and two did not know of any. With the young men, one had thought about suicide seriously, five knew friends/family that had died or attempted and four knew only distant stories. Nearly all the rural service providers and half the adults had known of suicides within their communities. When asked about their knowledge of existing suicide prevention services most young people (especially those who had previously accessed them) identified the following forms of professional support in their community (in order of frequency):

- counsellors (mostly school based with some public and private psychologists and psychiatrists also mentioned)
- kids helpline (free Australian crisis phone line for children and young people)
- school based education programs (self-esteem, anti-bullying, drug education etc)
- community health services (free public mental health, sexual assault & related)
- local doctor
- lifeline (adult crisis phone line with free access)
- local suicide prevention project and website (well publicised project)
- local government
- local hospital

Most young people said that they knew about these services through ‘word of mouth’ amongst peers and community networks, while some also mentioned seeing posters and advertisements on television. Among the adults interviewed there was a general lack of awareness (more male than female respondents) about specific services beyond phone help lines, school programs, counsellors and doctors. In contrast, service providers were clearly able to identify and name a comprehensive range of services within their geographic area (but often not in other areas). They also highlighted the different philosophical approaches that informed different professional practices. These differences were seen by them to be a source of tension informing the politics surrounding suicide prevention approaches and the power-knowledge relations that shape how suicide risk is understood for young people. For example, the multiple reasons behind suicidal behaviour were understood either as an individualised mental health problem or resulting from lack of community support and discrimination against young people, or often a combination of both. Xena, a local suicide prevention officer working within a community development project, makes the following comment about the professional tensions that form around the thinking and practices for dealing with suicide risk.

The types of services being offered are not appropriate...If you look at hospital or mental health services they are delivered purely from a biomedical model... Mental health still ‘owns’ suicide and it’s locked in that clinical model and this is a real issue. We’ve said to young people ‘seek help ok’. We have given them a range of models and a range of options to do that: from talking to their mum to seeing a mental health professional. But the bottom line is that if you find someone in trouble, what do you do? You tend to ring the expert. I know I’ve done it because I don’t want to be responsible for this young person topping themselves. While we are saying ‘the community’ potentially owns this issue, we also have to detect people at risk. We recognise there is no indicator that can predict suicide, so we refer to the experts who now own the issue. There are huge gaps with this and we have fewer and fewer able clinicians that have responsibility for counselling and ‘fixing the problem’. (Xena, suicide prevention officer)

Xena speaks of her sense of frustration with the way mental health services and knowledges work to make suicide visible in ways that emphasise individual pathology. Her own uncertainty about dealing with a suicidal young person is illustrative of broader dilemmas facing all professionals engaged in different ways with young peoples lives within a culture of increasing anxiety about risk and responsibility (Wilkinson, 2001).

Why Don’t They Just Talk To Someone?

Interestingly, if we look at the responses that young people gave to questions about the barriers that prevent help seeking, and thus increase suicide risk, we see different rationalities of risk than those linked to mental health disorder. Respondents were asked the question ‘who do you think is most at risk of suicide in your community?’ and most young people had difficulty talking explicitly about risk in relation to specific groups and tended to resort to individualised explanations. For example, they referred to personality styles (people who don’t talk about their feelings), the lack of knowledge about how to deal with difficult life events and emotions (relationship breakups, divorce). In addition, they mentioned the effects of managing multiple pressures (school achievement, work and unemployment, peer relations and status). However, in the responses that young people gave in relation to the question about ‘what stops young people seeking help when they

feel suicidal?' there were implicit risk discourses mobilised to explain the complex 'barriers' to help seeking. The responses from adults and service providers about barriers to help seeking were generally congruent with explanations of suicide risk evident within current policy discourses and they also drew upon their own contradictory experiences of dealing with young people in crisis. The most interesting comments revealed the contradictions and dilemmas of understanding young peoples' experiences of emotional distress in relation to help seeking as a rational risk minimising behaviour.

Nearly all the rural service providers and just over half of the adult participants could identify reasons why a young person might not ask for help. These ranged from a lack of services, not having an emotional language to speak about feelings, feeling ashamed about not coping with problems or having 'too much pride' to admit weaknesses, feeling alienated by negative community attitudes about youth and not having enough experience to deal with problems. While most adults could see the social context that might shape a young person's decision not to ask for help they largely employed an individualised discourse that emphasised rational choices and responsibility for seeking help. They often asked why a young person could not 'just talk to someone' instead of risking their own life. In these responses there was a sense of empathic failure and noticeable distancing of the adult self from the emotional turmoil of the suicidal young person.

Service providers had a range of experiences of working with young people and suicide, and they tended to emphasise the role of families and 'other' professionals in providing help and minimising risk. While many were able to identify risk and protective factors, they were often at a loss to know how to engage those young people who were not accessing their services. Hence, much of their experience related to working with young people who were able to seek help. Some professionals offered up their own reflections on growing up and living in rural communities, which revealed certain paradoxes in relation to their current roles. John, a student counsellor, reflects on the cultural sanctions that regulated his masculine identity and limited his helpseeking options. Yet, in his current role young men are expected to be able to come and talk openly with him.

Okay so I am a counsellor and what I do is I sit down and talk to people... I think back to when I was a young man I don't think I would have thought that talking about anything would really make a difference... It is not a doing thing... when you are with your mates you are doing things together you are not sitting there focusing on relating to each other. Like you may be feeling lousy then you will go and hang out with your mates and enjoy whatever you do and feel good for that time but you will then go away and still be stuck in what your stuck in ... it remains fairly private. (John, Counsellor)

John's comment suggests that helpseeking options for young men require a different kind of approach to understanding the provision and receipt of emotional support. The gendered nature of supportive interactions, identifying and managing emotional dilemmas and rituals of expression are all clearly identified. His paradoxical position suggests how professionals themselves can become caught up in expert discourses of risk management that work to invisibilise their own and young person's own affectivity. Risk discourses, by privileging a calculative rationality, work to reiterate a particularly managerialist expertise that can in turn generate more anxiety and uncertainty for the professional self. For example, the following comment by Suzy who is a parent, a psychologist and educator, points out the

effects of current risk discourses on professional and lay responses to youth suicide and emotional distress. She says,

...people know about the suicide data and think 'oh my god this person is going to commit suicide if I don't do anything about it'. So they get kind of panicky and that just makes the problem even worse...so that you don't actually process the emotional stuff at all. You very rapidly move from saying 'this is a person who wants to talk about their feelings and emotions' and rather than listening they say 'oh my god this is a person with a problem and let's ring up a psychiatrist or psychologist, I can't deal with it'. So you almost remove the opportunity for some interpersonal rapport or sharing and perhaps helpfulness. It just feels like too big a problem and it becomes really impersonal.

The reaction of distancing oneself from the young person struggling with suicidal feelings is identified here as emerging out of discourses that create pathways of referral that translate emotional distress into a problem of expert management of 'mental health risk'. In addition some professionals (eg., counsellors) also felt that there was a lack of acknowledgment by other professionals (eg., teachers) about the complexity of young people's emotional lives. Suzy also comments on how this lack of acknowledgment about emotion can lead to a mode of governance that ignores the affective dimension of self and individualises responsibility for young people's problems. Paradoxically young people are expected to be able to articulate their emotions and seek help from professionals who themselves may not be comfortable with those very same feelings. Suzy says,

...when I was counselling in college a lot of teachers did not use our service well. They either ignored the problem or thought it would go away or thought it was just normal teenage behaviour. They didn't always realise a professional service could play a role in helping students with those sorts of problems...I think one of the things about Australia is that we deal very badly with emotional stuff between people...I think young people get the message that your problem is not important, you will get over it, get your act together, and pull your socks up type of thing. And I think they clam up very quickly. I think by the time the young person is ready to tell a person that stuff they are taking a huge step into the unknown and if they get the slightest message the you don't want to know about it makes them shrivel.

In relation to her own experience as a parent Judy talked about how she felt that the increased reliance upon mental health professionals has led to a decline in those skills and abilities needed to resolve emotional dilemmas in everyday life. Judy is, in this sense, identifying the effects of institutionalised psy-expertise upon individual, family and community responses to risk. She says,

Stress and depression are being fed to us in the media... a lot of it is a normal part of life and can be dealt with and you can overcome it. Instead of people drawing on their own inner strengths, what do we do?, we run out and we have to get help and seek help... Now I know there are situations where you have to get professional help...But a lot of our own abilities I think have been taken away from us. We've been conditioned, oh you'd better go and, you know, check that out, get that, you seek help... (they were not much help to us when our daughter attempted suicide)... My daughter is just amazing now (she left the area and moved north). She has now learnt to draw more on her inner strength and intuition, gut feeling.

Appropriate Support in Rural Areas

The lack of appropriate support, intervention and prevention services was identified as a major barrier to young people seeking help and thus increased the risk of rural youth suicide. Sixteen out of the twenty young people and nine out of the ten professionals felt that there was a lack of appropriate support services in their rural communities. In contrast only half of the adult cohort spoke about a lack of appropriate services and instead tended to emphasise family responsibility (other families) for supporting young people. Although parents who had previous contact with mental health professionals when their daughter was suicidal felt alienated by confidentiality rules and at a loss to know how to support her. Young people felt concerned about inappropriate services, for example, a small community tried to establish a local helpline phone number staffed by volunteers. This was highly problematic because young people felt their confidentiality was compromised and it was hardly used. Other comments were made about local youth services being closed after hours, costs of therapy were prohibitive for many, the psychiatric unit in the hospital was felt to be intimidating and not youth friendly. Generic help line phone numbers were often very difficult to get through to at night and doctors were perceived to be too willing to dispense anti-depressant medication when presented with emotional problems. Broader prevention issues relating to boredom, a lack of recreational facilities and social venues that enabled a positive sense of youth identity, were also consistently mentioned by young people and some adults (see Fullagar and Sandwith, 2003).

Many of the young people in the study talked about the practices and rules governing rural culture that positioned them in precarious relationships with professionals. Fears about a lack of confidentiality with professionals in small towns that may know family members or friends were constantly reiterated in relation to the effects on identity – as a risk to one's reputation and social standing. Many young people felt that professionals occupied important roles in offering help, but were also central to the workings of small town surveillance. University student Tory, twenty one, comments on this phenomenon when she talks about rural inequities in service provision and the stigmatisation of mental health problems,

I think kids in rural areas are still so sort of underprivileged compared to metropolitan kids...we don't get the same options that kids in the cities get and it's bad enough when it's resources like education, but when it's stuff you really need, like to sort your head out... it's really hard to get that same confidentiality and get that same sort of privacy because everyone can see in everyone else's window and nobody has any secrets from anyone else... if you're in a small town you feel like people know, they're whispering about you...it makes it hard for kids in the country to do stuff about how they feel because I mean regardless of how the media is trying to de-stigmatise mental illness, it's still stigmatised.

A number of young people commented on how dissatisfied they felt with the way certain support services translated emotional distress into a clinical risk category that was then responded to in a formulaic way. University student Sophie, twenty, talks about her sense that either people do not take her experiences seriously (empathic failure) or that there is an immediate predetermined response to a perceived risk,

I can imagine some parents saying 'don't be stupid'. Some people don't take it seriously enough when someone says they are suicidal because they can't imagine

saying it or wanting to do it themselves...I reckon some young people would be sent straight to a psychiatrist...and it is very hard around here to find one. I remember when I was fourteen and I was referred to a psychiatrist and there was a year long wait.

Feelings of frustration resulting from young people's attempts to seek help often compounded the sense that no one was listening to the affective nature of their experiences or could respond to their complex emotions. Chloe, twenty three, reverses the position of the psy-expert to emphasise their lack of knowing about her risk experience. She says,

The first time I ever wanted a counsellor it really put me off... I was trying to tell her about my moods because I was just really, really depressed and she said, 'run a hot bath and put some bath things in it and maybe go for a walk' and I'm thinking, 'I'm wanting to slit my throat and you're like talking about a bath'. I said, 'okay' and I left... Like they're so dumb.

Risk Affect

It doesn't help people by thinking that they can't talk about their problems openly because, suicide is a taboo, it's not talked about openly... I think it's more a problem *not* to talk about it and to pretend that it's not an issue...it does heighten that sense of isolation, particularly I think in smaller towns where you're more likely to be recognised. (Max, twenty three, University student)

Max echoes a common concern that young people have about the taboo they feel surrounds suicide and talking about difficult emotions or tumultuous feelings. The overwhelming majority of young people in our research spoke about a range of 'barriers' to help-seeking linked to cultural norms that discourage the expression of emotion, inner turmoil, loss, sadness, shame, meaninglessness, depression, identity confusion, hopelessness and unworthiness. Young people talked about the stigmatising effects of mental health discourses on how they are perceived by others as problematic, abnormal and hence irrational. Being identified as having a 'mental health problem' by professionals, families and peers is to be a 'loser' or 'uncool' in a way that further excludes young people from the sphere of adulthood. The association of abnormality with speaking about emotions intensifies the feelings of shame, humiliation and unworthiness that young people say prevents them from safely expressing how they feel to others. Tory talks about these cultural sanctions through which young people govern their own emotional distress,

There's a big issue of shame with suicide. Like with depression it's *abnormal*. 'Oh you must be mental'. There's also the thing where people know that there is such a sense of shame with it, that they're not game to approach people. Like they think 'oh if I go to this person and tell them how I feel they're going to reject me, they're going to send me away, they're going to say, "oh I'm too busy or I don't want to know or just because you're mental don't bring it to me"'. That is just going to compound the situation... There aren't really that many places that are kid friendly. Like I mean you can go into a town like say Bordertown south and you've got community health places, but what kid goes into those?... it's sort of stigmatised...it's got a big sign on it and it's like arrows pointing to her saying, 'you're going in there'.

As Tory points out the social dynamics of shame position the young self in a paradoxical way where to ask for help is to risk further humiliation, and to not speak is to intensify the powerful affects that feed self condemnation for not 'handling things'. Scheff (1997: 210-12) argues that 'shame is the most frequent, and possibly the most important of emotions, even though it is usually invisible...Shame is the social emotion, arising as it does out of the monitoring of one's own actions by viewing oneself from the standpoint of others' (original italics) (for further discussion on shame and suicide, see Fullagar, 2003). The shame inducing experience of accessing mental health expertise points towards another risk discourse that many young people mobilised in their stories about the emotional and social relations of help seeking - that of risk affect. Risk affect is the qualitative, embodied, feeling dimension of suicide risk that is signified by emotional turmoil in relation to the meaning or meaninglessness of identity and relationships (loss, grief, anger, disengagement etc.). For many young people seeking help intensifies risk affect because it involves admitting to a lack of autonomy and adult status associated with the rational management of emotional life within neo-liberalism (Lupton, 1998). Misunderstanding risk affect can lead professionals to negate and dismiss the tentative expression and confused articulation of young people's help-seeking efforts. Suicide prevention requires another way of thinking about risk in terms of an affective relation or 'barrier' to help-seeking that requires a public discourse to counter taboo and open up dialogue about relations of care for self and others.

Concluding remarks

Within the risk rationalities of suicide prevention policy there is little room to articulate the affective nature of help seeking relations. Quantitative calculations of risk and protective factors can also work to prevent professionals from engaging in practices of critical empathy that open up different ways of engaging with young people in crisis or before they reach that point. This clearly significant emotional or affective nature of help seeking practices is rarely acknowledged within prevention policies that tend to privilege cognitive and behavioural aspects of the young self. Professional identity and practice are also constructed in highly problematic ways that increasingly rely upon risk assessment checklists and suicide prevention training that individualises emotional distress as 'warning signs'. Within our research young people responded creatively when asked about the kinds of services and community supports they would like to see in place to prevent suicide. Their responses emphasised the humanising processes of involving counsellors and psy-experts in youth specific practices to build trust and create opportunities for relaxed exchange and discussion. For example, having a local youth café, music events, arts festivals, a range of sporting and leisure options that involved, for example, counsellors in non-clinical encounters. This questions professional hierarchies and breaks down the division expert/lay, rational/irrational oppositions that separate the identities of young people and professionals. Having more information on services available, talking about how to manage emotions and who to turn to when things get tough, were frequent responses that identified risk affect but also other ways of engaging and building supportive relationships.

This article has argued that there is a paradox in contemporary mental health policies that promote help-seeking as a means of preventing youth suicide. Suicide policy does acknowledge the social and community context that reduces risk 'factors', but this requires further critical analysis in terms of how young people negotiate risk relations and often manage to find alternative ways of seeking help that are not steeped in shame or negative affect. In addition, the reliance on psy-experts to manage individual risk also raises the

issue of whether community members and families are losing confidence in dealing with young peoples' everyday emotional dilemmas and deeper crises of self. With a shortage of rural services there is a clear need to develop strategies to enhance the capacity of communities and professionals to engage with young people about the nature of support and a desirable culture of care. This may help to address the concerns that many young people have about a lack of confidentiality, trust in clinical relations and blasé attitudes that ignore the emotional dimension of becoming adult. For many young people (even those with diagnosed mental health disorders) mental health/illness discourses that dominant suicide prevention thinking work to privilege expert opinion at the expense of fostering empathic relations and creative alternatives. Within the context of our risk society the issue of how professionals are implicated in the government of young people's emotional lives (and deaths) creates a pressing need for further critical debate about the effects of dominant rationalities of risk. Although we cannot extricate ourselves from the influence of risk discourses we can nevertheless engage in the process of questioning the assumptions that inform policies and practices targeting suicide risk.

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