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Attempted suicide: Listening to and learning from young people

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Abstract

Suicide has become a major international health issue. Australia records one of the highest youth suicide rates in the world and Queensland has one of the highest suicide rates in Australia. This study sought insights into the suicide attempts of young men and women who survived. In-depth interviews were conducted in Townsville, Queensland, with a small group of young men and women aged 16-24 to explore the circumstances leading to the attempted suicide, the help sought and their suggestions for more effective intervention. The findings offer insight into the needs of local at-risk youth and provide suggestions for intervention services and future research.

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Susan Gair and Peter Camilleri

Suicide has become a major international health issue. Australia records one of the highest youth suicide rates in the world and Queensland has one of the highest suicide rates in Australia. This study sought insights into the suicide attempts of young men and women who survived. In-depth interviews were conducted in Townsville, Queensland, with a small group of young men and women aged 16-24 to explore the circumstances leading to the attempted suicide, the help sought and their suggestions for more effective intervention. The findings offer insight into the needs of local at-risk youth and provide suggestions for intervention services and future research.

> Was it a serious attempt? This is a question immediately asked in every case by everybody who gets to know about the attempt. (Stengel, 1969 cited in Goldney, 1981, p. 382)

Suicide has become a major health and public policy issue and it is one of the leading causes of death in young Australian males (Baume, McTaggart & Cantor, 1998). Australia records one of the highest youth suicide rates worldwide (17 deaths per 100,000 for Australians aged 15-24 and 23 deaths per 100,000 for Australians aged 25-44 in 1998 [Martin, Clark, Beckinsdale, Stacy & Skene, 1997]). Queensland ranks high when comparing Australia states (Commonwealth Department of Health and Aged Care (CDHAC), 1999). Some reports acknowledge that changes to coronial classifications in some states may, in part, explain rising statistics, but claim this cannot be a full explanation (Hassan, 1990; Tiller, Krupinski, Burrows, Mackenzie, Hallenstein & Johnstone, 1997).

Attempted suicide, whilst difficult to estimate due to lack of official records, is conservatively reported to be 30-50 times more common than completed suicides (Martin et al., 1997). Some Australian states record attempts if persons are admitted to hospital. However, it is believed this represents only a small proportion of attempts (Brent & Kolko 1990, Davis & Kosky, 1991).

Farmer (1982) defines suicide as death due to intentional self-inflicted injury. Attempted suicide is defined as intentional self-inflicted injury not resulting in death. Farmer and others believe that strictly speaking both involve an intent to cause death (Booth, 1999; Fabian, 1986; Farmer, 1982). Taylor (1982, p. 140) asserts that all suicidal acts are a 'gamble with death' and that differentiation between 'genuine' and other suicidal acts is not valid. Other writers disagree, arguing that most attempters (para-suicides) may not intend to die (Gregory, 1987) but rather they act out a quest for respite or escape (Beck, Schuyler & Herman, 1974; Parker, 1981).

Gregory (1987) implies that the term 'attempted suicide' even may be a misnomer suggesting that para-suicide can be viewed as a 'cry for help' utilising a particular kind of 'language' (see also Hassan, 1995). Martin et al. (1997) suggest that there may be thoughts of 'get[ting] back at someone' or needing 'someone special to take notice' (p. 5). However, others note that while it has been considered by mental health experts that 'manipulation of others' is a key motive of attempters, this is at odds with key motives identified by patients (Bancroft, Skrimshire & Simkin, 1979; Parker, 1981).

Tiller et al. (1997) suggest that there may be two categories of attempters: those who want to die but

survive; and those who respond to circumstances with a suicide gesture. On the other hand, Goldney (1981) reports that in a study of 110 young women who had attempted suicide by drug overdose three categories of intent emerged, with a high degree of suicidal intent and hopelessness evident in some attempters.

Use of violent or non-violent means is considered to be a relevant factor differentiating between attempted and completed suicides. Some research suggests that for attempters 'lethality of intent' may be reflected in the means chosen (Hassan, 1995; Ruzicka & Choi, 1999). However, others argue that choice of means is imbued with complex gender symbolism (Gregory, 1987; Hassan, 1995; Ruzicka & Choi, 1999).

THEORIES

Many theories can assist with understanding suicidal behaviour. These include Durkheim's theory of suicide which focuses on the strength and stability of an individual's ties to the society, Freud's thesis of anger and melancholia over the pain of lost love, and Erikson's lifespan psychosocial development stages. Behaviourists and cognitivists contribute with their perspectives of the importance of learning patterns and cognitive considerations. Attributional style is another important psychological theory. Additional sociological theories include societal (and individual) pathology, social disorganisation and breakdown (including dislocation, alienation and loss of cultural identity for individuals, groups and whole societies), value conflict, labelling and deviant theories. A structural view of suicide may highlight the impact on young lives of poverty and disadvantage.

In practice, a biological/medical model of mental illness features strongly among accepted theories of suicidal behaviour. Theories of grief, loss, crisis and attachment help inform a professional social welfare response to suicidal behaviour, while family systems theory, narrative theory and a client strengths perspective (Cowger, 1994) also provide guidance for practice. A poststructural perspective (incorporating symbolic interaction and role theories) may identify the use of language to devalue and render bad, mad or invisible certain groups. A social welfare approach recognises many of these theories as valid, including the narrative approach to documenting stories as adopted in this study, but acknowledges that all theories attract their critics (Aldridge 1998; Bainbridge, 1999; Brown, 1985; Hassan, 1995; Heckler, 1994; Hoff, 1989; Martin et al., 1997; Rubington & Weinberg, 1981; Taylor, 1982).

RISK FACTORS

Gender is one risk factor; young males are said to complete suicide at 3-5 times the rate of females in western societies. Most literature nominates females as much more likely to attempt suicide although some researchers question the accuracy of this gendered picture and believe that males may attempt at higher rates than are reported, and that unexpected female deaths, particularly from overdose, may be categorised less often than males as suicide and/or may be concealed by families (Davis & Kosky, 1991; Hassan, 1990).

Cultural background is a risk factor and Indigenous Australians are particularly at risk (Cantor & Slater, 1997; Queensland Health, 1997). Tatz (1999) and others argue that Indigenous suicide needs to be seen as contextually different to suicide in non-Indigenous groups (Hunter 1991). Of interest, Booth (1999) reports on two P acific cultures (Western Samoa and Fiji Indian) where suicide completions for young women are increasing and currently are higher than for young men.

Rural-urban status is another factor. Statistics indicate that in Australia most suicides occur in urban areas, although suicide rates in some rural areas have risen sharply in recent years (Cantor & Slater, 1997).

Further indicators of risk include loss, particularly the death of a loved one or peer to suicide, the loss associated with an intimate relationship breakdown and 'loss of face' (Ruzicka & Choi, 1999, p. 20). Other factors include family adversity, discord and fragmentation, family and personal history of mental illness, extremes in parental expectations, the frustration of unrealised autonomy, feelings of powerlessness, and feeling like a failure and a burden on others. Unemployment, lack of social supports, sexual-orientation discrimination, peer culture, substance abuse, experiences of violations, offending behaviours and feelings of alienation arising from an institutional admittance are further factors identified (Beautrais, 2000; Farrell, 1994; Hassan, 1990, 1995; Hoff, 1989; Hunter, 1991; Martin et al., 1997; Standing Committee on Family and Community Affairs, 1997; Vanatta, 1997).

Martin et al., (1997) identify that impulsivity is a risk factor. Currently in terms of prediction, a previous attempt is said to be a strong indicator (Serafino, Somerford & Codde, 2000). Research on attempted suicide is less common than on completed suicide and it has often been completed on patient populations, making generalisability unclear (Martin, Roeger, Dadds & Allison, 1997).

HELP-SEEKING BEHAVIOURS

Help-seeking behaviours have been the subject of several studies. Some studies have revealed that attempters have often visited general practitioners, psychiatrists and social workers in the month prior to an attempt although they may not have spoken about their suicidal thoughts (Hawton, O'Grady, Osbom & Cole, 1982). However, Tiller et al. (1997) state that almost 90 per cent of those who completed suicide made no specific attempt to seek help prior to the suicide, as far as could be retrospectively ascertained. Young people may be the least likely of all groups to have recently visited a GP (Haines, Hart, Williams, Davidson & Slaghuis, 1990). Gender may be an important factor in the helpseeking behaviour of young people (Kids Help Line (1996). Overall, it is suggested that increased understanding of those who attempt suicide and their help seeking behaviours, would be useful (Schonert-Reich & Muller, 1996).

METHOD

This small study sought to document the words of young men and women regarding a suicide attempt, and explore their help seeking behaviours and suggestions for intervention. A qualitative methodology underpins the study. A small sample of young people, who were willing to engage in in-depth interviews about their experiences of attempted suicide, was secured. Using a non-confrontational, conversational style, semi-structured, in-depth interview process (Minichiello, Aroni, Timewell & Alexander, 1996; Heckler, 1994), nine young people (five females and four males) in the Townsville district aged 16-24 were interviewed.

The sample was secured through media releases and assistance from Townsville General Hospital and several community-based youth services. One female participant identified as an Indigenous Australian and one as an Indigenous New Zealander (Maori). All other participants were assumed to be non-Indigenous Australians. Interviews were tape-recorded with permission, and transcribed. Confidentiality was assured with the exception that, if the researcher believed that life-saving intervention was needed, relevant mental health professionals would be informed. This exception was explained on the consent form.

The focus was on listening to young people's stories concerning their path to the point of the attempt. Participants spoke candidly on a wide range of topics including family, broken relationships, depression, deliberate self harm, their need for control over their lives, unemployment, drug and alcohol use, lost hope, life dreams and death plans. Some spoke passionately about their interests in poetry and environmental issues, about teachers who treated them as thinking adults and about the hard work of staying at school. This paper cannot address all the aforementioned experiences but does try to highlight

the path leading to the attempt, help-seeking behaviours identified and suggestions for improved services. Large quotes are considered necessary to present participants' stories (Heckler, 1994).

As researcher, I was aware of the extremely sensitive nature of the topic for participants (and for myself). Renzetti and Lee (1993) and Padgett (1998) speak at length about researching sensitive topics. Padgett (1998) asserts that the sensitive and probing nature of qualitative research almost guarantees that emotionally laden information will surface. She admits that Ethics Committees are often concerned that studies of sensitive topics may trigger a harmful emotional chain reaction for participants. Accessing a sample was much more difficult than was envisaged and it is considered that in part this may reflect the fears of some agencies of such an outcome for participants. However, Padgett (1998) declares that the very nature of qualitative interviewing mitigates against this if researchers are skilled and argues that the 'vast majority of informants welcome the opportunity to tell their story' (p. 63).

Shaffer, Garland, Gould, Fisher and Trautman (1988) have drawn attention to the possibility of distress when students are engaged in discussions about suicide. However, Martin et al. (1997) state that only those 'who have already considered suicide as an alternative are easily influenced and then not by questions and/or discussion, but only by another's death from suicide' (p. 7). No participant in this study became distressed during the interviews. Several young participants expressed comfort in the participant role, as this comment illustrates:

> Yeah this was pretty good talking about this, it was alright eh, when you first come I thought oh no I've got to talk about this stuff, but it turned out alright ... it was good. (Brad, aged 22 years)

FINDINGS

Young men and women in this small study spoke about experiencing many emotions including feelings of loss, depression, desperation and despair over relationships, feelings of letting significant others down particularly regarding schooling and employment, being a burden on family, feeling useless, facing a situation without hope of an acceptable outcome and feeling guilt and stress. These emotions, exemplified below, are consistent with the findings of other studies (Hassan, 1995).

> I felt a real failure. I had just left another school. I was the first person in our family to go to a private school ... my Grandad was so happy I had only been there like two weeks ... and I stuffed that up. I was really worried about my Mum, the stress it would put on her shoulders ... it was like the third one in a term and a half. I took a whole lot of tablets. (Sean 20 years)

> Well, the main reason I tried to kill myself was because my girlfriend left me and took my kid away from me ... so I got really depressed. I didn't think I could take it, didn't think I was worth anything anymore so I just didn't want to live ... I just took ... a cocktail of tablets. (Brad 22 years)

> I couldn't go to school without having diarrhoea or vomiting ... and I was putting a lot of stress on my parents. Yeah, what had happened that day, my dad was sick and I drove him to Cairns and ... I thought I was making my Dad sick ... and I thought yep I am going to do it. ... I went to my best friend and I let it all out and I said I've got to go, you know ... I felt like such a burden to my parents and I thought I'm no use to anyone, and ... I'm going to fail high school ... and I'm not going to get a job. ... I went home and went to the pantry - my mother is a nurse so we had every drug in the house and I knew which ones to take. I had my mind made up. I took a big glass of water I took a heap of them and then took the rest. Mum heard me. I have never been that low again, not even when I took those tablets (another attempt). I didn't want to kill myself ... I still wasn't that low that I wanted to kill myself ... I just didn't

> want to be in the world for a while. (Lena, 20 years)
>
> I just broke up with my girlfriend, I was working a lot, studying lots and 1 had a lot of guilt and stress and I couldn't handle it ... I think I had been sort of depressed (over a number of years) I started using drugs again after a couple of years. I came home drunk one night I was out with friends one of the worst (nights) of my life. I slit my wrists. I was just feeling low and couldn't escape it. ... It wasn't so much about dying it was just more about getting out ... tried to hang myself twice and two overdoses. The last few times it built up over a couple of hours or even a couple of days ... but this last time it was within ten minutes, bang, I had to do it. ... That (last) time I was more serious about doing it and getting it right. (Lilly, 22 years)
>
> Well, with the first [attempt] a flat mate said she was feeling down and she came to see me and I spent about 15 minutes talking to her and then I said 'this is a crock of shit, I'm going to take some pills too' - about 90 tablets - and she changed her mind and rang her boyfriend. ... I remember they removed the tube which was down my throat and I turned my head and my parents were there and I said 'why aren't I dead?' The third time was after a sort-of boyfriend tried to suicide in our flat ... tried to hang himself, and I remember when I was giving him mouth-to-mouth and calling the ambulance I wondered 'should I be doing this?' and I sat for about an hour after that and then I cut my arms with a razor blade and I remember thinking there is not much blood and there should be ... and I changed my mind and I got my arms stitched. (Jen, 20 years)

Suicide literature highlights gender differences in means used and argues that, to a large degree, the high figures of completed suicides for young men can be explained by the violent means chosen. Correspondingly, it is considered that the means chosen by young women can explain the high female figures of non-fatal attempts. Participants in this study did not necessarily choose non-violent means. Drugs were chosen in many instances but hanging, attempting to jump before a moving object and use of weapons were described. There were few differences in gender use of means in this study. More female participants reported multiple attempts than young males, which is supported in the literature (Hassan, 1995; Hawton, Fagg & Simpkin, 1988).

It appears that survival of attempters at times was the result of impromptu or sought rescue as well as lethality of means. Seriousness of intent is definitely alluded to by participants. For example, Brad, Lena, Lily and Jen appear to self-identify those attempts where they were 'more serious' or they 'just didn't want to live anymore', while other attempts were 'just more about getting out'.

What is of grave concern is that some young men and women appear to have been overwhelmed with an emotional crisis, (including the attempt of others) which prompted an impulsive attempt. Martin et al. (1997) and Tiller et al. (1997) identify impulsivity as a factor. Somewhat paradoxically, Martin et al. (1997) state such attempts may be predictors of future attempts.

Impulsivity in suicidal adolescents is thought to be linked to deficit skills in rational appraisal and problem solving. Problem-solving skills, including delayed decision making have been recommended (Kashden, Fremouw, Callahan & Franzen 1993; Tiller et al., 1997). Gregory (1987) notes that attempters, for a range of reasons, may keep company with others who have attempted and this is evident in one of the quotes.

Help seeking behaviours

Participants spoke of feeling reluctant to ask for help, of seeking help, of doubting the benefits of help, and of betrayal of helpers:

> I find it hard to ask for help ... I think that has just been a part of my personality. I have always been the man about the house, (I) do all the hard work. Like my grandad - he's very self-sufficient sort of person I just couldn't see him asking for help. My mum ... works in a health setting. I think that had a lot to do with me actually asking for help. She gets hold of a lot of material for me. I learned a lot about it (depression), that it's not my fault, I can't deal with it myself ... that most people can't. It all came flooding back I asked mum 'take me to a doctor I need some help. (Sean, 20 years)

> I had been seeing a counsellor at school a couple of weeks before but it hadn't been long enough. It is just so hard to break into someone's mind when they don't understand their minds themselves. What can she do? (Lena, 20 years)

> I went to a counsellor once at school the only time ever I decided okay well I have got to do something. It was eating me inside, right ... and I had spoken to her and, no lie, ten minutes later she was in the Principal's office. (Delilah, 16 years)

> I would make a call (to family or friends) except for the last overdose because my sister said I have to say goodbye before I do anything. (Lilly, 22 years)

> Well, I rang Lifeline after I took a lot of pills and well I'm still alive so it must have helped. I saw a counsellor at the Women's Centre once and the Case Manager at Cambridge Street is good. (Jen, 20 years)

Participants reveal that they have reached out for help in the past to significant others, to counsellors and to community based services. School counsellors feature in a number of comments as a considered avenue for help. Participants also identified what may inhibit or facilitate these help-seeking behaviours. For example, male role-modelling did not facilitate help-seeking ('I just couldn't see him [Grandad] asking for help') nor did a school counsellor going straight to the Principal facilitate trust or help seeking. A lack of conviction or knowledge that the counsellor may be able to help or understand may inhibit help-seeking. Alternatively assistance from family, for example, a parent supplying information on depression and a sister who insisted on a 'goodbye', did assist help-seeking. Tiller et al. (1997) and others found that suicidal young people may not know where to seek help, may believe that others cannot help or that it is inappropriate to seek help, but that many teenagers seek help from their families, including mothers and fathers (Schonert-Reich & Muller, 1996). Kids Help Line (1996) reports that gender is a factor in help-seeking with males more likely than females to ask parents than friends for help, and that confidentiality was an important consideration in choosing a helper.

Suggestions for help

Related to the above discussion, participants identified a range of strategies which could inform intervention services. Gaining information about depression is described by some participants as significant.

> I think more education in schools would have helped me, if someone had come along and said what depression is, and some of the side effects - if you feel like this there is somewhere you can go. I think someone coming to the house, I feel a lot more comfortable inside my house, because I know I'm not going to go somewhere and see some guy I used to go to school with sitting in the waiting room. I find it much easier to talk to a female rather than to males. I think having difficulty talking to a male comes from that males should be macho and rah, rah, rah. (Sean, 20 years)

> It needs to be really carefully done ... talk to the person first, find out how they feel and then

> pass on (to family) what they have said with their permission. Yeah, a social worker. Well, I don't know just listen and maybe don't try and pry it out of them, you know, just listen. ... Maybe get them to talk to a friend and ask if you can be there, maybe they're more comfortable that way. One thing that did help is knowing that this (depression) is a disease. (Lena, 20 years)
>
> I think maybe something like an appointment once a week, like a community worker from a drop-in-centre, ... if they were caring and understanding easy to approach ... paid attention to what I wanted to say. (Lilly, 22 years)
>
> I think, like the ad on TV for child abuse ... it's good, it's a really good ad. Well, they need an ad like that to take away the stigma of attempts, like you are not crazy, and have groups of young people out bush and reading books and stuff like that. (Jen 20 years)
>
> The thing is they have all these suicide programs, counsellors and what have you, I don't know the answer but they haven't got it at the moment .They can open a counsellor shop on every street corner and I guarantee you not one young person who really and truly wants to kill themselves will walk in there. I mean, you talk to your friends don't you? They need people on the streets, I reckon you need young people like us though, Counsellors have this big front. Counsellors say 'don't do it' and try to stop you... 'I say in three months time ... we will be doing this and that and you will be in your grave and I'll be putting fresh flowers on you.'... Look at the reality, you know, ... young people talking to young people. Get those young people on the dole out there talking to other young people a work-for-the-dole counsellors thing, you know. (Tina, 18 years)
>
> Sharehouse (workers) aren't counsellors. They do talk to you but they are also there as mates, ... and here as well (Open Youth Project). ... The counsellor has to be your mate or you aren't going to talk to them. (Mandy, 16 years)

Some participants in this study recommended school-based support. According to Glover, Burns, Butler and Patton (2000) schools have great scope to contribute to a supportive community environment. Glover et al. (2000) identify that higher rates of young people report depressive symptoms than any other age group, and Keys Young (1997) report that young respondents in their study believe young people need more information on depression. The need for a reduction in labelling and shaming is also recommended by participants. This could be aided by providing a home visiting/outreach service, and by positive media coverage to reduce the stigma of suicidal thoughts. In fact, the influential (often negative) role of the media on the topic of suicide has been identified by researchers (Fabian, 1986; Hassan, 1995).

Participants identify that peers who were specifically trained in the role of helper, and workers who listen, and whose approach to suicidal young people is direct, genuine and constituting a 'mate' role, would be welcome. Healey (1997) advises that doctors and teachers can miss subtle suicide warning signs and that 'suicidal young people did not trust the police or social workers' (p. 19) and do not know how to contact counsellors. He recommends that health workers build more trusting relationships with young people.

Rogers (1961), still authoritative today, cautioned against aloof professionalism but also against the offer of friendship without negotiation or marshalling of available services, information and laws which service users require in the face of discrimination or social exclusion (see also Weeks, 2000). Holman (1995) identifies such a role in that of the resourceful friend. Similarly, Lynn, Thorpe, Miles, Culls, Butcher and Ford (1998, p. 79) identify informal 'friendship work' as useful in working with Indigenous Australians, while Frazer (2000) speaks of two Melbourne street workers who declared that 'the last thing they need is another worker to give advice and counsel; they need a friend' (p. 49).

DISCUSSION

Martin et al. (1997) recommend crisis intervention in youth suicide intervention. This would seem appropriate for those overwhelming crises described here by some young people. In a recent stocktake of youth suicide prevention services, 4 per cent of community education and community development services and up to 20 per cent of other services utilised crisis intervention and primary care interventions (Mitchell, 1999a, 1999b). Yet, few supplied a rapid response or 24 hour crisis or emergency intervention other than hospital emergency wards. Such wards have been credited with seeing only 10 per cent of adolescents who attempt suicide (Patton & Burns, 1998).

Mitchell (1999b) calls for further research into the cost-effectiveness of intervention based in Accident and Emergency Departments, considering the low proportion of attempters who present there, and calls for further exploration of community based options. A recent study of youth deliberate self-harm in the Cairns region (Far North Queensland) called for a 24-hour harm minimisation unit (Storck, no date). It seems that a joint government and local, community-based service that can specialise in rapid response (24 hour) to urgent distress is needed, particularly when impulsivity appears to be a factor in suicides and attempted suicides. Intersectorial school and community approaches, including expanded welfare services, have been recommended (Commonwealth Department of Human Services and Health, 1995; Camilleri, 1997; Hart, 1990; Majda & Zorbas, 1998).

Dey (1993, p. 35) believes that 'ambiguity of meaning' is pervasive in communication. Young people, in particular, may not have 'a language for their feelings' (Daniel, Wassell & Gilligan, 1999, p. 12) or may use youth culture language. Piper (1999, p. 32) identifies that previous attempters nominate 'being listened to' as important in preventing further attempts. Workers may need to actively listen for ambiguity of meaning and 'insider shorthand' (Powell, 2000, p. 13), be tuned in to each individual, and hear young person's perspective on their unique experiences and intent.

A priority is that local resources, including families, peers, significant others, workers and schools be marshalled to arm young people with information on stress and depression. Such information was very helpful (even lifesaving) to several young people in this study. These groups could also be encouraged to teach, role model and facilitate the learning of competent problem solving skills and skills for clear articulation of needs.

Schools have been identified as a source of stress for some adolescents (Callaghan, 2000; Rigby, 1996). Further, the possibility of distress when students are engaged in discussions around suicide has been noted (Shaffer et al., 1988). Yet it is known that secondary schools are very well placed to play a focussed, positive, legitimate and responsible role in educating young people about suicide prevention (Glover et al., 2000; Gostelow, 1990). Integrated approaches are underway in many schools (Wyn, Cahill, Holdsworth, Rowling & Carson, 2000).

Tertiary institutions may be well placed to play a role in better preparing those professionals working with young people regarding suicide prevention (Hunter Institute, 1997) Professional workers or counsellors who are able to establish and maintain a 'friend/mate' role rather than a 'helper/counsellor' role are recommended. Outreach/home visiting services also seem important.

An interesting observation from the research literature is that it refers to 'youth' suicide but often focuses on young men. This is understandable given the dramatic increase in young male suicides in recent decades (with a slight reduction recorded recently). For young women, suicide completions have declined over recent decades (with a recent increase), but attempts are very common (Healey, 1997). Gender is considered in the suicide research literature, yet greater exploration of gender differences seems warranted.

From the research literature it is apparent that suicide rates are not fixed (CDHAC 1999; Hassan, 1995; Ruzicka & Choi, 1999); nor are lethality, access, and means. Drugs, poisons and gases have been the means used by women and some men in the past and the survival of att empters in the last decade has been attributed in part to reducing lethality of chosen drugs/poison/gas and advances in intensive care technology (CDHSH, 1995; Hassan, 1990). Male suicidal deaths by firearm have reduced (through restricted access) but hanging suicides have increased for both young men and young women. One recent trend is the selection of more lethal methods in young women (Ruzicka & Choi, 1999).

A study by Booth (1999) reports on two Pacific cultures where suicide completions for young women are higher than for young men. It could be argued that such trends are culture specific and cannot be extrapolated to other cultural groups. Indeed Tatz (1999) and Hunter (1991) argue for the importance of cultural context. However, Brice, Radford and Van Der Byl (1990) remind that similar proportions of Indigenous Australian women and men suicide in custody. Further, gender differences in suicide for all Australians are less distinct for rural areas (CDHAC, 1999).

Overall, suicide (attempted and completed) is a serious Australian health issue. Many young males are dying and young females and males are emotionally, psychologically and physically wounding themselves each year. This small study reveals that multiple attempts are being made by Townsville young people, particularly young women, and that survival sometimes was accidental rather than planned. Increased research at local and national levels with at-risk young women (and men) should explore gender-common and/or gender- specific buffers which might better safeguard all young men and women.

CONCLUSION

This research investigated the thoughts, actions and perceptions of a small group of young people concerning their own attempted suicide and their help-seeking behaviours. The findings reveal that their suicide attempts were characterised by seriousness of intent. However, there can be a rapid onset of perceptions of an insoluble situation leading in turn to an impulsive rather than planned action. Young people in this situation need support to resolve their difficulties.

These young people sought help from a range of persons and services leading up to the suicide attempt, including school counsellors, community-based workers and families. However, this was not always helpful. What they say they wanted was 'genuine listening'. What seems to be needed is available, trustworthy support-workers who can fill a 'mate' role.

Improved school-based strategies and approaches are urgently needed. Families can help, particularly supplying information about depression. A flexible outreach service that is well-known to young people and a support service that could respond rapidly could contribute to a multi-layered approach to intervention.

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