IT HAS NOT YET BEEN DETERMINED THAT YOUNG COMPLETED SUICIDES represent a distinct entity, separable from other age groups. Nor has it been determined that the younger age group represents a homogeneous group (Maris 1985; Neiger & Hopkins 1985). However, comparisons between young suicide and older suicide groups show both distinct similarities and distinct differences.

An increasing risk of suicide is associated with increasing age (MacIntosh 1985), with the highest rates found among those aged 65 and over. Within the adolescent group, there is a steady increase in suicide rate from approximately 15 years of age. The risk of suicidal behaviour is significantly reduced below this age (Neiger et al. 1988). The seriousness of suicide among the older groups is largely ignored because of an increasing focus on the young. Adolescent suicide remains the age group with the lowest suicide rate (Osgood 1982). A survey of community attitudes showed that all age groups ascribed a higher risk to older people (Domino, Moore, Westlake & Gibson 1982).

Marked increases in male youth suicide rates have been reported along with a slight decline in female youth suicide rates (Moens, Haenen & Van de Voorde 1988). Completed suicide is traditionally associated with a higher incidence among males (McClure 1984; Dyck, Newman & Thompson 1988; Burvill 1980; Dorsch & Roder 1983; Paerregaard 1980; Frederick 1978). While surveys have found that adolescent males do predominate

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Preventing Youth Suicide

(Neiger et al. 1988; Joffe, Offord & Boyle 1988; Kotila & Lonqvist 1989), other epidemiological studies have found significantly more females complete suicide in the adolescent group (Maris 1985).

The self-destructive behaviour of both the younger and older age groups may reflect suicidal careers that represent a progressive failure of attempts at adaptive behaviour. Despite this, it has been reported that the younger age groups are significantly more likely to have made multiple attempts prior to completing the act (Maris 1985).

The frequency of use of a particular method of suicide is related to the availability of that method. A significant decrease in the number of deaths from domestic gas poisoning occurred in England and Wales following the detoxification of domestic gas in 1963 (McClure 1984). The use of drugs is now the most common method in these countries. Although the patterns of suicide in England and Australia are very similar, one distinguishing factor is the large number of suicides by use of firearms in Australia (Snowdon 1979). The use of firearms is also disproportionately high in the United States (Frederick 1978). In contrast, death by firearms is exceedingly rare in Singapore where very strict gun control laws are in force (Kau & Tsoi 1985). A study in the United States comparing the severity of gun control measures in different states showed that the overall suicide rate is lower in those states with the most severely restrictive gun laws (Lester & Murrell 1982; Lester 1988).

It has been hypothesised that the higher suicide rate among the older age groups reflects the use of more lethal methods (MacIntosh 1985). However, while both the young and the older age groups use firearms as a means of suicide (Maris 1985), youth suicide is most associated with their use (Moens et al. 1988; Brent et al. 1988). A significant risk factor for young completed suicide has been reported to be the availability of firearms in the home (Brent et al. 1988).

There is no real difference in the likelihood in terms of suicide notes between the young and older groups. The age of the writer is not associated with either the length of the note or the number of notes left (Lester & Reeve 1982). While the desire to die is not communicated differently in the suicide notes of the two groups, the younger group communicate more inwardly directed aggression (Lester & Hummel 1980), are less concerned with feelings than actions and are more explicit about the forthcoming suicidal action (Lester et al. 1982).

Both young and older suicides are likely to be described as 'social misfits' and both groups are more likely to have experienced negative social interactions and social losses (Maris 1985). Dependent on the population studied, social isolation has been found to be significantly related to youth suicide (Moens et al. 1988) and older suicide (MacIntosh 1985).

An examination of interpersonal conflict and loss as a precipitating factor in completed suicide indicates that multiple personal loss, bereavement and serious family argument are significant risk factors in completed suicide in the older age group (Osgood 1987). However, an investigation of a youth suicide sample showed that 70 per cent had experienced interpersonal conflict immediately prior to death (Brent et al. 1988).

Family dysfunction appears to have a greater influence on the young (Joffe et al. 1988). Youth suicide has been associated with multiple problems in the family of origin (Maris 1985) and family relationships are characterised by a lack of support and instability (Neiger et al. 1988).

Older suicide has been associated with the occurrence of adverse life events. Recent widowhood and a major life move are significant predictors of suicidal behaviour (MacIntosh 1985; Osgood 1982). The status changes that occur during older age are also associated with the suicide act, for example, retirement, loss of job, lessening of independence and loss of income (MacIntosh 1985; Osgood 1982). However, both
groups have been found to be exposed to repeated stress and long standing problems prior to death and both groups have been found to perceive death as an escape from intolerable situations (Maris 1985). Adverse life events as precipitants of suicide in the young significantly more often reflect disciplinary crises or the anticipation of such (Diekstra 1985). While both groups are affected, it is possible that the young are more deeply affected by social stresses such as unemployment, marital breakdown and family disintegration. A survey of community attitudes revealed that a social stress is a more acceptable reason for suicidal behaviour for the younger group (Diekstra 1985).

Unemployment has been linked to increasing adolescent suicide in the United States (Seiden & Freitas 1980) and with young adult suicide in Australia (Meares, Kraiuhin & Benfield 1983). Younger suicides are less likely to have ever worked and have fewer financial resources (Maris 1985).

Physical illness as a reason for suicide is not significantly related to youth suicide. Older suicides are reported to have been in poorer physical condition and to have had poorer recuperative power (MacIntosh 1985; Osgood 1982).

In contrast, psychiatric illness has been associated with both young and older completed suicide (Joffe et al. 1988; Maris 1985) with depression being the most common diagnosis (Maris 1985; Brent, et al. 1988; Osgood 1982; Neiger et al. 1988). The depression in the young may differ from depression in the older group in terms of somatic symptoms with the younger group reporting very few (Osgood 1982). In addition, a diagnosis of depression in the young suicide group is more commonly associated with comorbidity of substance abuse (Brent et al. 1988). While one study reported that 72 per cent of the sample aged between 19 and 29 were known to psychiatric caregivers (Runeson 1989), a lack of previous mental health treatment has also been reported (Brent et al. 1988).

Young suicides are reported to have displayed a high level of risk taking and impulsivity prior to death. Their self-destructive behaviour is more likely to be based on anger and hostility. Linked to both these factors is the greater use of alcohol and drugs prior to death reported in the adolescent samples examined (Maris 1985).

Adolescent suicides are significantly more likely to have modelled the suicidal behaviour (Maris 1985; Phillips 1974; Phillips 1982; Phillips & Carstensen 1986; Phillips & Paight 1987). Consistent with a mechanism of contagion is a recent increase in time space clustering of adolescent suicide. Although the underlying reason for the clustering cannot be determined from this type of analysis, contagion is assumed to be mediated by three pathways: direct contact with the suicide; hearing of the event without direct contact; and indirect transmission via the media (Gould, Wallenstein & Kleinman 1990).

Although research has been conducted in an attempt to identify the similarities and differences between young and older completed suicides, many of the factors found to be significantly related to these groups may reflect age differences alone. That is, these differences would be found when comparing non-clinical or community groups so may not be considered pathogenic.

Method

The suicide data were obtained from the coroner's inquest files held at the Tasmanian Archives Office and the Tasmanian Government Law Department. All files between 1968 and 1987 with a coroner's decision of suicide or an open verdict were analysed. A decision was made to evaluate the cases with an open verdict and to include those cases as suicide that met the following criteria:
Preventing Youth Suicide

(a) the method by which death was caused was typical of those used by suicides, for example self-poisoning and hanging;

(b) an expression of suicidal intent was made either verbally or by note, in the weeks and day preceding the attempt;

(c) a history of suicidal behaviour;

(d) the presence of potential precipitating factors such as mental or physical illness or a stressful life event; and

(e) evidence of psychological/emotional distress in the days and weeks leading up to death.

A case was judged as suicide if either of criteria (a) or (b), and one other criterion was present. This decision was made in an attempt to achieve a more realistic description of suicide in Tasmania as a coroner's decision may be influenced by factors such as the age of the deceased or the presence of family members at the inquest (Kosky 1982; Farmer 1988; Platt, Backett & Kreitman 1988). Underreporting of suicide has been found to diminish with increasing age and is less common in recent years. The underreporting has been found to be greater in young female suicides, although this has not substantially altered suicide rates and trends (Moens et al. 1988).

Two raters were involved in the collection of the data. A test of inter-rater reliability showed agreement of a case as suicide at 97 per cent.

Six categories of method of suicide were determined. They included use of firearms, hanging, drowning, drugs, gas, and other methods. The category of 'other methods' included, for example, death by precipitation, self-immolation, cutting and stabbing, electrocution, asphyxia or the use of poisonous substances other than drugs. None of these methods were used with sufficient frequency to allow a separate category.

Results

Total sample

During the twenty-year period, 1968 to 1987, 1051 individuals suicided in Tasmania. This resulted in a mean yearly suicide rate of 12.85 per 100,000 in the Tasmanian population.

When considering the total sample, analysis showed no significant change in total suicide rate over the twenty years of this study. As expected, significantly more males than females suicided in Tasmania, the mean suicide rate for males being 19.29 and for females 6.47.

The mean suicide rate for individuals aged between 10 and 19 years was significantly lower than statistically expected at 4.53. The highest suicide rate, at 22.66, was found among individuals aged 40 to 49 years. This was significantly higher than statistically expected.

The lowest mean suicide rate for both males and females occurred in the 10 to 19 year age group. There was a steady increase in mean female suicide rate with age, peaking at age 40 to 49 years, and decreasing thereafter. Male suicide rate showed a sharp increase between the age groups 10 to 19 years and 20 to 29 years and remained high thereafter.
Comparisons between youth and adult suicide

Comparisons were made between those suicides aged 19 and less and those aged 55 and over. Seventy individuals aged between 12 and 19, and 299 aged between 55 and 92 suicided in Tasmania in the period under investigation.

Significantly more adolescent males than expected completed the suicidal act. Males constituted 86 per cent of the adolescent sample against 70 per cent of the older sample.

There was no significant difference between the two groups in terms of a previous suicide attempt. Twenty-five per cent of the adolescent sample and 17 per cent of the older sample had previously attempted suicide. The communication prior to death of the intention to suicide did not differ between the two groups: 57 per cent of the adolescent sample and 51 per cent of the older sample. There was also no difference in the proportions of the two groups leaving a suicide note.

The younger group was significantly less likely to have had a recent visit to a general practitioner, was less likely to have been under medical supervision, was less likely to be in poor health and was less likely to have been admitted to a general hospital in the twelve months prior to death.

The younger group was significantly less likely to have had a recent psychiatric consultation, was less likely to have been under psychiatric supervision, and were less likely to have been admitted to a psychiatric hospital.

An examination was made of the individual's state of mind and behaviour in the days leading up to death. The information was extracted from the reports given at the inquest hearings. The younger groups were significantly more likely to have been displaying normal behaviour in the days before death; were significantly more likely to be angry, hostile or violent; and were more likely to be behaving impulsively or recklessly. The younger group was significantly less likely to be sad, tearful or depressed and were less likely to be confused or absentminded. The two groups did not differ in terms of anxiousness or distress, withdrawn or quiet behaviour, erratic or bizarre behaviour, changeable moods, the appearance of being calm or resigned, and sudden or unusual cheerfulness. An examination of the blood alcohol levels determined at post mortem revealed that the younger group were significantly more likely to be intoxicated at the time of death.

Reports from significant others and the content of suicide notes were used as a source of information to determine possible reasons for suicide. The younger group was significantly more likely to have suicided because of interpersonal conflict or loss and an adverse life event or avoidance. The younger group was also significantly more likely to have modelled the behaviour, although direct contact with another individual who had suicided did not differ between the two groups. The younger group was less likely to have suicided because of psychiatric illness, physical illness or social isolation.

An investigation of the method of suicide used by the two groups revealed that the younger group was significantly more likely to have used a firearm. Although the majority of the older group also used a firearm, the proportion in this group was not as high as for the younger group: 56 per cent of the adolescent group and 33 per cent of the older group. Examination of the trends over the twenty-year period showed an increasing use of firearms and a decreasing use of drugs for both age groups.

Discussion

An examination of the literature combined with the results of this study suggest that adolescent suicides are not an homogeneous group. However, this is true of any other age group. Although some factors are highly associated with suicidal behaviour, a typical suicidal profile does not exist.
This study emphasises the point that adolescents comprise the group least at risk of suicidal behaviour. The relative invulnerability of the young in relation to completed suicide has been infrequently addressed and cannot be readily explained. A range of factors which correlate with suicidal behaviour and on which adolescent and older suicides differ may hold significance for this finding.

As reported in the majority of studies, this investigation found males predominate in the adolescent group. The claim that both age groups have similar suicidal careers is supported by this study. No differences were found between the two groups in terms of previous attempts or communication of the intention to suicide which may be shaping the behaviour.

The use of firearms was overwhelmingly the most common method of suicide in this adolescent group. If the availability hypothesis of suicide is accepted, the presence of firearms in the home must be accepted as a high risk factor, in light of the adolescent's impulsive and reckless behaviour. The absence of gun control laws poses an unacceptable risk to the community in light of these findings. The results of this paper provide a further indication of the urgent need for review of the accessibility of firearms in the general population.

Despite the well reported social isolation of both young and older suicides, this study found that social isolation as a reason for suicide was more likely in the older group. However, this may be presenting a biased picture as the information was largely taken from reports of significant others, most commonly parents. It is possible that young people are assumed by parents to have many friends. In addition, the older sample may be more willing to admit to social isolation than the younger sample.

The multiple personal losses and conflict reported to be common in the older group are outweighed in this sample by the proportion of the younger group that were considered to be influenced by this factor in their decision to suicide. This may be due to higher levels of family dysfunction and greater family instability for the younger group (Joffe et al. 1988; Maris 1985; Neiger et al. 1988).

Although it has been hypothesised that the older group experience more adverse life events, it has also been suggested that the younger group are more deeply affected. This is supported by the fact that adverse life events and avoidance were more likely to be the reason for suicide in the younger group. This deep influence may reflect a lack of coping strategies needed to face and solve these types of situations.

There was no evidence of a high incidence of psychiatric disorder in the younger sample. Although depression has been found to be the most common diagnosis, the younger group were significantly less depressed in the days leading up to death. Although it was stated that mental illness was related to youth suicide and 72 per cent of one sample had had psychiatric contact, this study coincides with the report of significantly less mental health treatment for the younger group (Brent et al. 1988).

This study again provides evidence that modelling is an important factor in suicide of the young. The media should be encouraged to balance the tragedy of youth suicide with its frequency. Adolescent suicide rates are the lowest of any age group and are, therefore, the group who are coping most successfully.

Despite the limitations, a profile of an adolescent suicide in Tasmania is a male who is physically well and who has never had contact with mental health services. In the days leading up to death he is angry or hostile although this appears to be his normal behaviour. He behaves impulsively and recklessly and is drunk at the time of death. He suicides because of interpersonal conflict, most commonly with family, and because he faces an
adverse situation such as a disciplinary crisis. Death is achieved with the use of a firearm, a readily available means of suicide.

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