Cultural dimensions of youth suicide

Richard Eckersley
National Centre for Epidemiology and Population Health
The Australian National University
Canberra ACT

Introduction

This paper is about the social context of suicide, especially its cultural dimensions. Studying this context means understanding complex systems, which comprise many entities that interact in often multiple, weak, diffuse and non-linear ways. Specifically, it also means coming to terms with the rich intricacy and subtlety of the interplay between social conditions, individual circumstances and personal states of mind.

In other words, behaviours such as suicide represent an intensely personal response to a complex pattern of social, economic, cultural and environmental changes that is occurring the today's world. For example, teenage violence in the United States has been attributed, at least in part, to an 'apocalyptic nihilism' that is infecting children today (Powers 2002). In a world stripped of meaning and self-identity, adolescents can come to understand violence as 'a morally grounded gesture, a kind of purifying attempt to intervene against the nothingness'; they can think and act 'as though it's an extremely late hour in the day, and nothing much matters anymore'. Other problems among youth, including eating disorders and deliberate self-harm, can also be seen as 'attempts to intervene against the nothingness', or a deeply human need 'to transform the passive experience of suffering into something we can actively control' (Stone 2004).

One useful way to study complex systems is through synthesis: rather than constantly refining the questions asked and the methods used to obtain more certain answers, synthesis involves drawing together knowledge from across disciplines and the sciences and humanities to produce new understanding (Eckersley 2004: 8-15). Synthesis raises several important conceptual issues. It strives for coherence in the overall picture rather than precision in the detail; It dispenses with expectations of scientific certainty and exactness, especially with respect to cause and effect; everything is provisional, and relationships often reciprocal. It challenges Occam's Razor, which states that entities must not be unnecessarily multiplied – that is, the simplest theory that fits the facts corresponds most closely to reality – by recognising that entities may need to be multiplied beyond what seems at first to be necessary. It acknowledges that any attempt to impose a logical story on the world distorts its reality.

Synthesis allows us to move beyond the usual scientific emphasis on differences - between the ill and the well, the marginalised and the mainstream, the disadvantaged and the privileged, males and females - to explore the ways in which changes that affect everyone can, nevertheless, affect people differently and contribute to specific problems that only some experience. It draws attention, not so much to how people are coping with, or adapting to, these changes, but to whether the changes are, in their overall effects, positive or negative: do they enhance, or diminish, human wellbeing and potential.

The relationships between a systemic, population perspective and other approaches to health can be represented in a three-dimensional diagram depicting the determinants (proximal to distal), dimensions or scales (individual to global) and definitions or outcomes of health (mortality and morbidity to wellbeing) as three axes (Figure 1). Almost all the health research and health care dollar is spent at or near the junction of the three axes – addressing individual cases of death and disease and the proximal or immediate factors that cause or contribute to them. This is the domain of clinical or curative medicine. As we move out along the three axes we pass through, generally speaking, the domains of traditional epidemiology, with its emphasis on population patterns of mortality and morbidity, but with a focus still on individual risk factors, and the 'new' epidemiology, which is taking greater interest in the more distal determinants, to the social sciences, with their broader concerns with social conditions and the human situation, including a view of health as total wellbeing, not just an absence of illness and disability.

[Insert fig 1 about here]

There are other important features of a population-health perspective that can be expressed in several principles or observations, which build on the work of Rose (1992):

1. The primary determinants of health are mainly social, economic and cultural; therefore health issues need to be addressed from these perspectives.
2. There is a positive relation between the population mean of a characteristic and the prevalence of deviance; put another way, prevalence is inversely related to severity.
3. Explanations for health differences between individuals may differ from those for differences between populations; that is, causes of cases may be different from causes of incidence.
4. A small reduction in risk in a large, low-risk population will usually improve health more than a large reduction in a small, high-risk group.
5. Prevention, where possible, is better than cure.

This paper uses synthesis and a population-health approach to examine the social basis of suicide, focusing on the cultural determinants of youth suicide and with particular reference to Australia and Japan.

Youth suicide in Australia and Japan

Youth suicide rates in Japan and Australia over the past 50 years are mirror images of each other, especially the male rates (Figure 2): in Japan, they were very high in the 1950s and into the 1960s, then fell steeply until the 1990s when they rose; in Australia, they were low in the 1950s, then rose steeply until the 1990s, when they began to fall (a pattern also apparent in other Western nations) (Eckersley and Dear 2002, De Leo and Evans 2003).

A colleague Keith Dear and I recently analysed youth suicide rates across developed countries, including Australia and Japan, and found a strong positive correlation between male rates and several measures of individualism (Eckersley and Dear 2002). Correlations between female rates and individualism were also positive but weaker. In other words, youth suicide rates were highest in the most individualistic countries; the more personal freedom and control over their lives young people felt they had, for example, the higher the suicide rate (Figure 3).

Male youth suicide was also positively associated with subjective measures of health, optimism and trust, while individualism was positively associated with both these and other quality-of-life variables, including happiness and life satisfaction. Correlations between suicide and other possibly relevant cultural variables, including tolerance of suicide, belief in God and national pride, were not significant. Nor were correlations significant between suicide and various socio-economic factors, including poverty, youth unemployment, divorce, inequality, social welfare expenditure and per capita income (which is not to say that none of these things matters, only that a link did not show up in this broad-brush analysis).

[Insert figs 2 & 3 about here]

The simplest explanation of the association between suicide and individualism is that the greater the sense of freedom in life, the more likely people are to choose death. Indeed, suicide might well be regarded as an ultimate expression of individual freedom of choice and control over one's life. But the results suggest there is more to our findings. They present an internally consistent pattern that raises intriguing questions. On the face of it, they indicate that higher youth suicide is associated with not just freer youth, but happier, healthier, and more optimistic youth, so suggesting that youth suicide rises as social conditions and personal prospects improve. Or is there another explanation, linking higher suicide with greater social adversity, which seems intuitively more likely? Put another way, are the suicidal 'an island of misery in an ocean of happiness', or 'the tip of an iceberg of suffering'?

Other studies appear to support the 'island of misery' argument, and researchers have offered three possible explanations: first, as life improves, people have fewer outside sources to which to attribute their unhappiness so are more likely to blame themselves; second, the greater happiness of most increases the misery of the few; and third, that something like increasing freedom is good for the majority but bad for a minority which

3

can't handle it (Eckersley and Dear 2002). These explanations fit the facts of the research, but there are two principal reasons for challenging this interpretation. The first is that the association of higher suicide rates with higher quality of life may result from cultural differences between countries in how people respond to questions about life. It is possible, for example, that compared with collectivist societies people in individualistic societies rate their wellbeing higher because it is more important to consider themselves happy, health and optimistic - in other words, to be a winner.

The second, and more compelling, reason is that the 'island of misery' hypothesis can hold true only if the evidence shows that the suicidal are indeed part of a small, distinct minority within a population of young people who are thriving and whose wellbeing has improved over recent decades. But the evidence does not do this. Instead, the facts, when we cast the net of evidence much wider, support the 'tip of the iceberg' hypothesis. They show that rising suicide represents one end of a spectrum or gradient of distress and suffering that, in less severe forms, affect a much larger proportion of young people and which have also become more prevalent over time.

So Dear and I concluded that the results of our cross-country analysis supported the hypothesis that increased youth suicide reflects a failure of Western societies to provide appropriate sites or sources of social identity and attachment, and, conversely, a tendency to promote unrealistic or inappropriate expectations of individual freedom and autonomy. Our study found significant correlations only between individualism and youth suicide (correlations were not significant with all-age suicide rates). This finding can be explained in terms of young people's greater vulnerability, as discussed later. However, other recent studies have found more general associations between suicide and individualism (Rudmin et al 2003) and social fragmentation (an individualism-related factor) (Whitely et al 1999).

The association between individualism and suicide is consistent with Emile Durkheim's (1897: 361-92 [1970 ed]) observation in his seminal study of suicide over a century ago that a crucial function of social institutions such as the family and religion was to bind individuals to society, to keep 'a firmer grip' on them and to draw them out of their 'state of moral isolation'. 'Man cannot become attached to higher aims and submit to a rule if he sees nothing above him to which he belongs', he wrote. 'To free him from all social pressure is to abandon him to himself and demoralise him.' Durkheim saw clearly the distinction between material and moral causes of despair. In a comment particularly relevant to modern times, he said: 'If more suicides occur today than formerly, this is not because, to maintain ourselves, we have to make more painful efforts, nor that our legitimate needs are less satisfied, but because we no longer know the limits of legitimate needs nor perceive the direction of our efforts.'

The findings of our study are also in line with the conclusions of a major international review in 1995 of the evidence on trends in psychosocial problems such as depression, drug abuse, suicidal behaviour and crime among young people in Western nations (Rutter and Smith 1995). It concludes that social disadvantage and inequality are unlikely explanations for the increases in psychosocial disorders. Amongst its recommendations,

4

the study called for further investigation of the theory that shifts in moral concepts and values were among the causes - in particular, 'the shift towards individualistic values, the increasing emphasis on self-realisation and fulfilment, and the consequent rise in expectations'.

The costs of individualism are likely to be greatest in the 'new' industrialised nations such as Australia, New Zealand, Finland, Norway (all of which attained full national status only in the 20th century), the United States and Canada. The cultures of these countries – certainly the English-speaking nations - are more clearly defined by the related 'virtues' of progress, materialism, mobility (both social and geographic) and individualism, and perhaps less tempered by tradition and social obligation. It is among these nations that youth suicide has increased most and is now highest. This is not to claim individualism is the only factor affecting youth suicide. Historically high rates of youth suicide in the Germanic nations and Japan, and their dramatic decline in the latter, suggest the influence of other sociocultural factors.

In Japan, the high rates in the 1950s might reflect the traditional Japanese tolerance, even approval, of suicide and that it was a time of social trauma, upheaval and restructuring in the wake of the Second World War. The decline in suicide since 1960 might, then, reflect the Japanese national resurgence, especially economically, and a weakening of norms relating to suicide. And it could be that the recent rise in youth suicide reflects a rise in individualism that has accompanied, and has probably been associated with, the prolonged economic stagnation of the 1990s and 2000s.

The fall in youth suicide, especially in male rates, in the 1990s in countries that have seen the biggest rises - including Australia, New Zealand, United States and Canada – does not weaken the argument for a link with cultural trends such as individualisation (Figure 4). First, hospitalisations of young people for emotional and behavioural problems and intentional self-harm have increased over the period suicide rates have fallen (AIHW 2003: 98), and psychological distress increased among males aged 20-29 between 1995 and 2004 (Jorm and Butterworth, in press). These findings suggest more troubled youth are seeking and getting help, rather than that fewer young people need help. Secondly, one possible explanation for the decline, consistent with the first reason, is the greater public awareness and recognition of the problem, with the result that suicidal young men feel less isolated and more likely to seek help, and parents, teachers and friends are more alert to their needs.

[Insert fig 4 about here]

As one19-year-old told Reach Out!, an award-winning on-line youth suicide prevention service (www.reachout.com.au): 'Reach Out! made me realise that other people go through what I'm going through and somehow that makes it easier to cope'. Another site visitor wrote: 'I really enjoyed reading the stories of others who have been through hard times. It made aware I wasn't alone…I feel more in touch with people my own age…It just makes me feel good to be alive.' These comments suggest this increased awareness is

a problem-specific response or counter to the wider social context of individualism and the social isolation to which it gives rise.

Culture and health

The specific link between suicide and individualism, and culture more broadly, is strengthened when we look at the wider research into the effects of the social environment on health, which has surged in the past two decades. The research establishes the links between suicide and other psychosocial problems, and shows that these problems share common social determinants (De Leo and Evans 2003, Loxley et al 2004). The focus of attention has been on socio-economic disadvantage and inequality, especially income inequality.

However, recent research challenges this narrow focus (Eckersley, in press). Instead, the research shows that population health is the product of a complex interaction of history, culture, politics and economics, and between broad social conditions and individual risk factors. This recognition opens the way for a greater examination of cultural influences, as does a second recent research development: a general acceptance that psychosocial factors are a significant pathway by which inequality and other social determinants affect health, and that perceptions and emotions are important to health outcomes.

This position is now common ground between those who believe that sources of health inequalities are primarily, or fundamentally, material - resulting from differences in material exposures and experiences – and those who argue their sources are psychosocial – stemming from people's position in the social hierarchy and their perceptions of relative disadvantage. Once we allow a role in health for psychosocial factors and for perceptions, expectations and emotions, then cultural factors have to be considered because culture powerfully influences these things.

Culture's role in creating and shaping meaning and the qualities that contribute to it – autonomy, competence, purpose, direction, balance, identity and belonging – is particularly important to young people because these attributes are the destinations of the developmental journeys they are undertaking. And it is among the young that the rise in psychosocial problems has been marked over recent decades (Rutter and Smith 1995; Eckersley 2004: 147-69). Broadly speaking, between one fifth and one third of young people today are experiencing significant psychological distress and disturbance at any one time (for example, depression, anxiety, substance abuse, serious suicidal thoughts and behaviour) (Figure 5, 6). Taking a still wider measure, malaise (measured as headaches, stomach aches, insomnia and tiredness), the proportion experiencing high levels of malaise can rise to about a half (depending on country, age, gender and other factors) (Figure 7).

[Insert figs 5, 6 & 7 about here]

The need to look beyond socio-economic disadvantage in explaining recent patterns and trends in psychosocial disorder in young people has been reinforced by recent studies that

suggest that children in affluent families, although usually seen as being at lower risk, may in fact be more likely than other children to suffer substance use problems, anxiety and depression (Luther 2003). Two factors appear to be implicated: excessive pressures to achieve and isolation from parents (both physical and emotional). Both these factors can also be seen as expressions of cultural factors such as individualism, shaped and accentuated by affluence.

The social determinants research understands 'culture' mainly in terms of 'subcultures' or 'difference', especially ethnic and racial, and so, usually, as one dimension of socio-economic status (Eckersley 2001, 2004). Culture in the broader sense of a system of meanings and symbols that shapes how people see the world and their place in it and gives meaning to personal and collective experience, has been given scant attention in the recent social determinants literature. Of the many books and reports on the subject published over the past two decades, only a few give cultural determinants more than a passing mention.

Generally speaking, the influence of culture (in this broad sense) on health and wellbeing has been seen as distal and diffuse, pervasive but unspecified. Yet it seems plausible, if not self-evident, that cultural characteristics can have as important an impact on psychosocial factors such as social support and personal control as socio-economic inequality – perhaps even more important. Marmot and Wilkinson (2001), in noting the relationship between income inequality and social affiliation, suggest there is a 'culture of inequality' that is more aggressive, less connected, more violent and less trusting. A culture of materialism and individualism could also be all these things – and more.

The neglect of mainstream culture is perhaps not surprising. Cultures tend to be 'transparent' or 'invisible' to those living within them because they comprise deeply internalised assumptions and beliefs, making their effects hard to discern. A second factor is the extent to which the impacts of culture are 'refracted' through a host of other, more specific influences, including a person's personal circumstances and temperament (this is also true of other distal determinants of health).

Culture can impact on health at several levels. Within populations, it could influence levels of inequality – for example, through the part individualism plays in market-oriented political doctrines that are associated with greater inequality. It could also interact with socio-economic status to moderate or amplify its health effects - for example, materialism and individualism might accentuate the costs of being poor or of low social status by making money more important to social position and weakening social bonds and group identity. But culture's role is perhaps more important in explaining health differences between populations, or changes in a population's health over time.

There are many 'isms' by which we can characterise modern Western culture, but two of the most important and best researched are materialism and individualism (Eckersley 2001, 2004: 43-58). Research shows that materialism - the pursuit of money and possessions, of a lifestyle based on the consumption of market goods and services –

seems to breed not happiness but dissatisfaction, depression, anxiety, anger, isolation and alienation (Kasser 2002). People for whom 'extrinsic goals' such as fame, fortune and glamour are a priority in life tend to experience more anxiety and depression and lower overall wellbeing - and to be less trusting and caring in their relationships - than people oriented towards 'intrinsic goals' of close relationships, personal growth and self-understanding, and contributing to the community.

Individualism, which places the individual self at the centre of a framework of values and beliefs and celebrates personal freedom, is another cultural hazard. It is supposed to be about freeing us to live the lives we want, but it may in fact be doing the opposite. Researchers describe the downsides in different ways: a loss of social cohesion; a heightened sense of risk, uncertainty and insecurity; a lack of clear frames of reference; a tyranny of excessive choice; the perception that the onus of success lies with the individual, regardless of the social realities of disadvantage or privilege (Rutter and Smith 1995; Furlong and Cartmel 1997a, 1997b; Schwartz 2000).

One aspect of Western individualism that may be particularly problematic is a mistaken expression of autonomy as independence or separateness. Autonomy is a matter of volition, the ability to act according to our internalised values and desires (Chirkov et al 2003). Its opposite is not dependence, but heteronomy, where we feel our actions are controlled by external forces regardless of our own values and interests. Confusing autonomy with independence may not only reduce belonging or relatedness, it could also reduce our sense of control over our lives by encouraging a perception that we are separate from others and the environment in which we live, and so from the very things that influence our lives (Eckersley 2004: 87-96). There is also a second mechanism by which individualism might reduce personal control: independent individuals require high self-esteem, and one way to maintain that self-esteem is to believe that the things that threaten it are beyond our control. The creation of a 'separate self' could be a major dynamic in modern life, impacting on everything from citizenship and social trust, cohesion and engagement, to the intimacy of friendships and the quality of family life.

Social perspectives on population health must also take personality into account because new research shows that our personalities are changing in ways that may impact on the psychosocial pathways between social conditions and health (Eckersley 2004: 90-94). For example, a series of studies by Twenge and her colleagues drawing on psychological tests conducted with American children and college students over periods of up to sixty years has found increases in trait anxiety (or neuroticism), self-esteem, extraversion and, in women, assertiveness, while sense of control over life had declined (that is, locus of control had become more external). The studies link most of these trends to rising individualism and freedom. Economic factors such as unemployment and poverty seem not to be involved.

Trait anxiety and reduced control have been associated with a range of poor health outcomes including depression, suicidal behaviour, and alcohol and drug abuse. Even in the case of the seemingly positive shifts, the benefits of high self-esteem are now being challenged and, as noted above, it may work against personal control. And while

extraversion is associated with higher wellbeing, its combination with the other psychological changes could lead to a more narcissistic or 'contingent' self-esteem, which requires constant external validation to be sustained – in other words, an extrinsic orientation that is associated with lower wellbeing.

An important means by which cultural qualities such as individualism and materialism affect wellbeing is through their influence on values (Eckersley 2004: 49-56). Values provide the framework for deciding what is important, true, right and good, and have a central role in defining relationships and meanings, and so wellbeing. Most societies have tended to reinforce values that emphasise social obligations and self-restraint and discourage those that promote self-indulgence and anti-social behaviour. Virtues are concerned with building and maintaining strong, harmonious personal relationships and social attachments, and the strength to endure adversity. Vices, on the other hand, are about the unrestrained satisfaction of individual wants and desires, or the capitulation to human weaknesses.

A similar picture emerges from reading what sages have said about happiness through the centuries. A couple of themes recur. One is that happiness is not a goal but a consequence: it is not something to be sought or pursued, but a result of how we live; related to this, it is not found by focusing just on ourselves and our own needs, but on those of others as well. A second theme is that happiness comes from balancing wants and means, from being content with what we have. Our materialistic, individualistic culture undermines, even reverses, universal values and time-tested wisdom.

Beyond the specific links between culture and health, surveys also show that cultural factors lie behind a widespread public perception of declining quality of life in Western societies (Eckersley 2004: 105-25). Many people are concerned about the materialism, greed and selfishness they believe drive society today, underlie social ills, and threaten their children's future. We yearn for a better balance in our lives, believing that when it comes to things like individual freedom and material abundance, we don't seem 'to know where to stop' or now have 'too much of a good thing'. For example, an Australian study found over a half of those surveyed felt quality of life was falling, with the most common reasons given being, in order: too much greed and consumerism; the breakdown in community and social life; too much pressure on families, parents and marriages; falling living standards; and employers demanding too much (Pusey 2003). Most people believed family life was changing for the worse, citing the breakdown of traditional values; too much consumerism and pressure to get more money and buy things; a breakdown of communication between family members; and greater isolation of families from extended family networks and the community.

In summary, the evidence suggests that individualism and materialism are powerfully and mutually reinforcing in their negative impacts. Broadly speaking, it would seem that they have produced a self that is socially and historically disconnected, discontented, insecure; pursuing constant gratification and external affirmation; prone to addiction, obsession and excess. Large numbers of people are medicating themselves to 'take the edge off the 21st century', to use one expression. We see these failings clearly in the lives of

Hollywood-style celebrities, whose glamour, fame and wealth are so often a glittering veneer over deep insecurities, addictions and self-absorption. Acknowledging these pervasive cultural impacts helps us to understand why young people's wellbeing appears to have declined in recent decades despite the psychosocial benefits that should have flowed from increased social tolerance, diversity and pluralism, including greater gender, religious, ethnic and racial equality.

Wellbeing and resilience - the capacity to restore or maintain wellbeing in the face of adversity – derive primarily from being connected and engaged, from being suspended in a net or web of relationships and interests, which provide love, security, purpose, belonging and identity. This web allows us to achieve a balance of meaning in life (and so guards against excess, addiction and obsession), and sustains us when one or more of the threads or strands break (through death, separation, job loss etc). Traditionally this web was woven for us; meaning in life was a social given. Today we have to weave it ourselves, to our own design; meaning in life has to be chosen, or constructed, from a proliferation of options.

Redefining Western culture

The search for meaning – or its creation - is often seen as a 'luxury' of the materially rich, even a self-indulgence, as illustrated by the axiom: 'No food, one problem. Much food, many problems'. But this is not true. The need for meaning is a human constant; it has been part of us since the dawn of human history. It is a crucial dimension of human health and wellbeing. As Nietzche said: 'He who has a *why* to live for can bear with almost any *how*.' Yet, as I have argued, Western culture emphasises the 'how' of life, not the 'why'.

One of the most important and growing costs of our modern way of life is, then, 'cultural fraud': the promotion of cultural images and ideals that do not meet human psychological needs, nor reflect social realities. To the extent that these images and ideals hold sway over us, they encourage goals and aspirations that are in themselves unhealthy. To the extent that we resist them because they are contrary to our own ethical and social ideals, they are a powerful source of dissonance that is also harmful to health and wellbeing.

Given that this cultural fraud is becoming increasingly global, responding to it may require different strategies by Eastern and Western, collectivist and individualistic, nations. For Australians (and other Western people), the solution is probably not a return to institutionalised, collective forms of meaning, but a different sort of individualism - an enlarged, socially connected individualism that offers us the opportunity to become truly moral beings, perhaps for the first time in history. As Bauman (1995: 43) points out, people today are forced to stand face-to-face with their moral autonomy, and so also with their moral responsibility. 'This is the cause of moral agony. This is also the chance the moral selves never confronted before.' Beck says these new orientations create 'something like a cooperative or altruistic individualism' (Beck and Beck-Gernsheim 2002: 162). 'Thinking of oneself and living for others at the same time, once considered a contradiction in terms, is revealed as an internal, substantive connection.' For Japanese

(and other Eastern people), the cultural evolution could involve coming from the opposite direction – from a strong tradition of collective identity – but might perhaps converge towards the same point of morally responsible and socially bound citizens.

Cultures bring order and meaning to our lives. Of all species, we alone require culture to know how we should live and to make life worth living. We stand at one of those times in history that are marked by parallel processes of cultural decay and renewal, a titanic struggle as old ways of thinking about ourselves fail, and new ways of being human strive for definition and acceptance At the broadest social and cultural level, then, addressing the problem of suicide is tied to the outcome of this contest.

References

ABS, 1998. Mental Health and Wellbeing: Profile of Adults, Australia 1997. ABS cat. no. 4326.0. Canberra: Australian Bureau of Statistics.

AIHW, 2003. Australia's Young People: Their Health and Wellbeing 2003. AIHW cat. no. PHE 50. Canberra: Australian Institute of Health and Welfare.

Bauman, Z. 1995. Life in Fragments: Essays in Postmodern Morality. Oxford: Blackwell.

Beck, U, Beck-Gernsheim, E. 2002. Individualization. London: Sage.

Chirkov, V, Ryan, RM, Kim, Y, Kaplan, U. 2003. Differentiating autonomy from individualism and independence: a self-determination theory perspective on internalization of cultural orientations and wellbeing. J Pers Soc Psychol; 84: 97-110.

De Leo, D, Evans, R. 2003. International Suicide Rates: Recent Trends and Implications for Australia. A report by the Australian Institute for Suicide Research and Prevention for the National Advisory Council on Suicide Prevention, Commonwealth of Australia, Canberra.

Durkheim, E. 1897. Suicide: A Study in Sociology. London: Routledge and Kegan Paul, 1970.

Eckersley, R, Dear, K. 2002. Cultural correlates of youth suicide. Soc Sci Med; 55: 1891-904.

Eckersley, R. (in press) 'Cultural fraud': the role of culture in drug abuse. Drug Alcohol Rev.

Eckersley, R. 2001. Culture, health and well-being. In Eckersley, R, Dixon, J, Douglas, B, eds. The Social Origins of Health and Well-being. Cambridge: Cambridge University Press.

Eckersley, R. 2004. Well & Good: How We Feel & Why It Matters. Melbourne: Text Publishing.

Furlong, A, Cartmel, F. 1997a. Risk and uncertainty in the youth transition. Young; 5: 3-20.

Furlong, A, Cartmel, F. 1997b. Young People and Social Change: Individualisation and Risk in Late Modernity. Buckingham: Open University Press.

Jorm, A F, Butterworth, P. (in press). Changes in psychological distress in Australia over an 8-year period: evidence of worsening in young men. Aust NZ J Psychiat.

Kasser, T. 2002. The High Price of Materialism. Cambridge, Massachusetts: MIT Press.

Kessler, R C., Berglund, P, Demler, O. et al, 2003. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA; 289: 3095-105.

Loxley, W, Toumbourou, J W, Stockwell, T et al. 2004. The Prevention of Substance Use, Risk and Harm in Australia: A Review of the Evidence. Monograph. Ministerial Council on Drug Strategy, Commonwealth of Australia, Canberra.

Luthar, S S. 2003. The culture of affluence: psychological costs of material wealth. Child Dev; 74: 1581-93.

Marmot, M, Wilkinson, R G. 2001. Psychosocial and material pathways in the relation between income and health: a response to Lynch et al. BMJ; 322: 1233-6.

Powers, R. 2002. The Apocalypse of adolescence. The Atlantic Monthly, March.

Pusey, M. 2003. The Experience of Middle Australia: The Dark Side of Economic Reform. Cambridge: Cambridge University Press.

Putnam, R D. 2000. Bowling Alone: The Collapse and Revival of American Community. New York: Simon & Schuster.

Rose, G. 1992. The Strategy of Preventive Medicine. Oxford :Oxford University Press.

Rudmin, F W, Ferrada-Noli, M, Skolbekken, J-A. 2003. Questions of culture, age and gender in the epidemiology of suicide. Scand J Psychol; 44: 373-381.

Rutter, M, Smith, D J, eds. 1995. Psychosocial Disorders in Young People: Time Trends and Their Causes. Chichester: John Wiley and Sons for Academia Europaea.

Sawyer, M G, Arney, F M, Baghurst, P A et al. 2000. The Mental Health of Young People in Australia. Australian Government Publishing Service, Canberra.

Schwartz, B. 2000. Self-determination: the tyranny of freedom, Am Psychol; 55: 79-88.

Stone, A.A. 2004. From Barbie to body piercing. Australian Financial Review, 12 March, Review pp. 8-9 (reprinted from Boston Review).

Whitely, E, Gunnell, D, Dorling, D, Davey Smith, G. 1999. Ecological study of social fragmentation, poverty, and suicide. BMJ; 319: 1034-7.
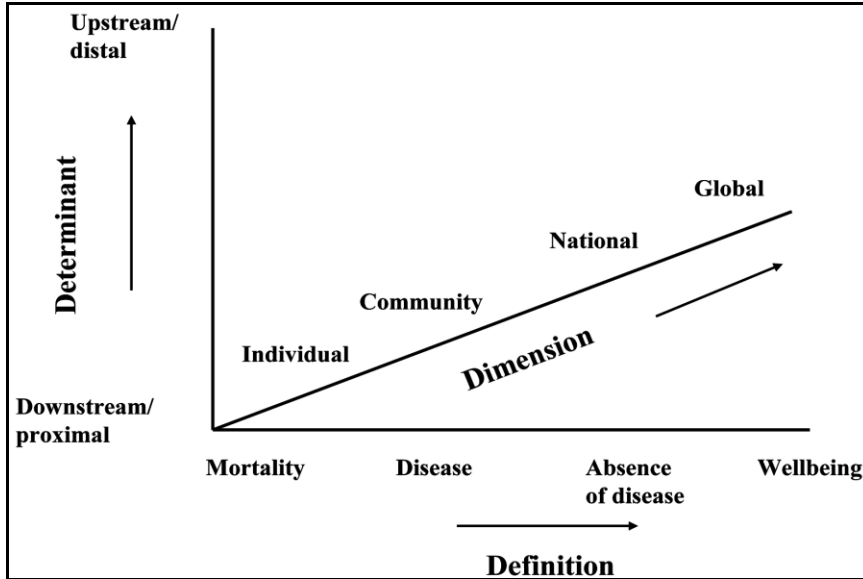
Figures

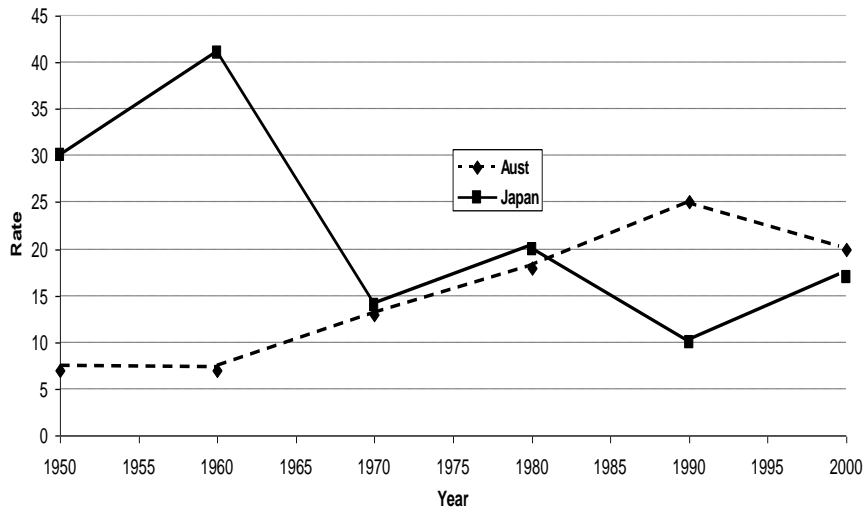Figure 1: A three-dimensional representation of health and wellbeing.

Figure 2: Suicide rates for males, 15-24, in Japan and Australia, 1950-2000 (trends are indicative only, being based on single year rates at about decadal intervals). Source (Eckersley and Dear 2002; De Leo and Evans 2003).
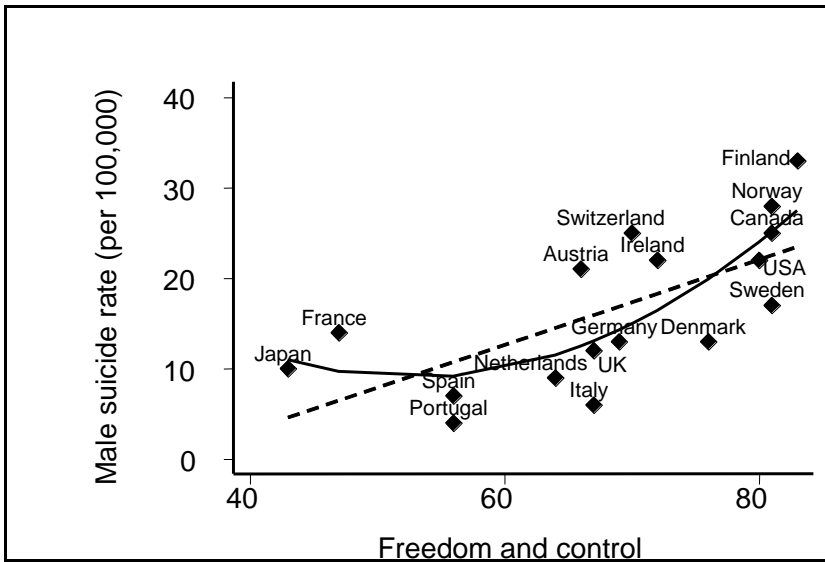
Figure 3: Suicide rates for males 15-24 (1991-93) and individualism by country. Individualism was measured by the proportion of people 16-29 who agreed in a 1991-93 World Values Survey question that they had a great deal of free choice and control over their lives. [A quadratic model shows significant curvature in the relationship (p = 0.032) and increases the multiple correlation from r = 0.68 for the linear model to r = 0.76]. Source: Eckersley and Dear 2002.
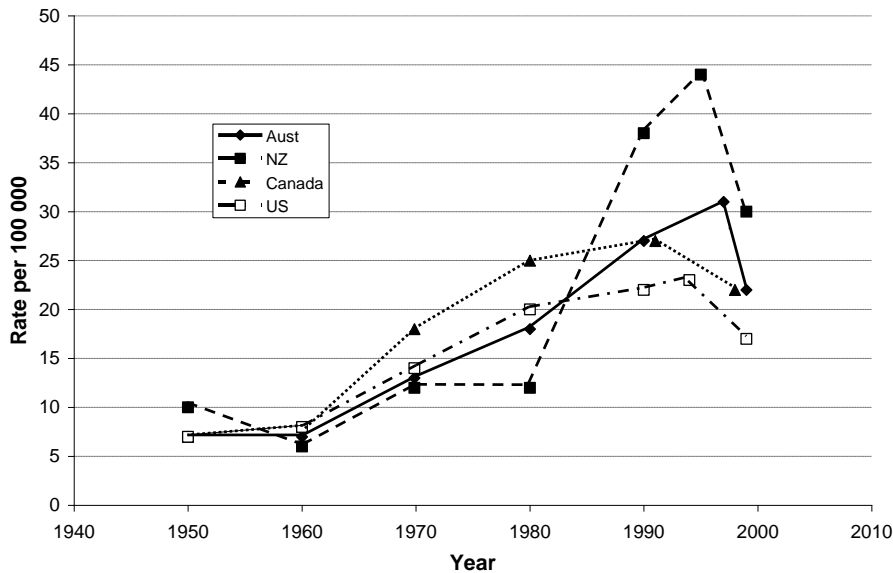

Figure 4: Trends in male youth suicide for four countries, 1950 – 2000. Trends are approximate, being based on single year rates at roughly decadal intervals, but with peak years included. Source: Source Eckersley and Dear 2002; De Leo and Evans 2003; personal communication with various individuals.
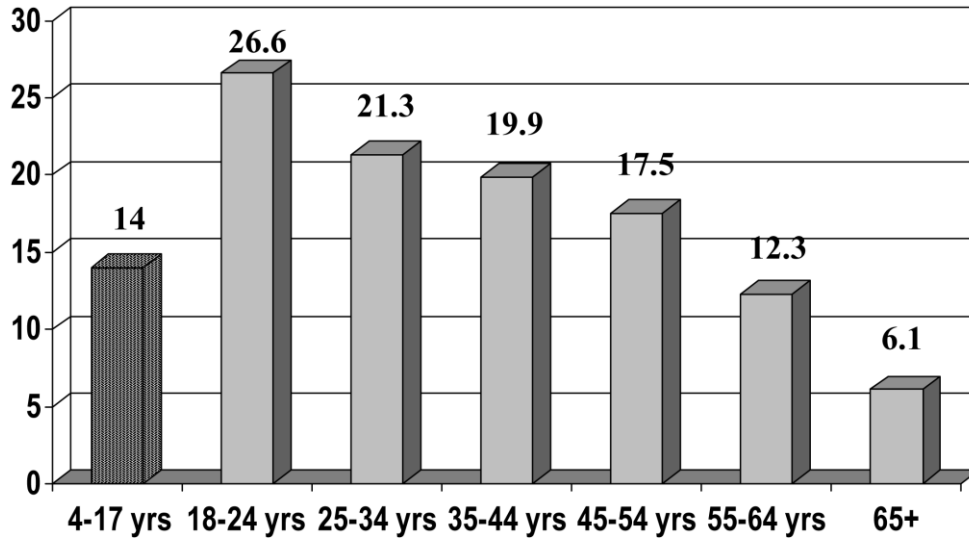
14

Figure 5: Prevalence (per cent) of mental health problems among Australians, by age. The prevalence for children is at the time of the survey; for adults it is over the previous 12 months. Source: ABS 1998; Sawyer et al. 2000.
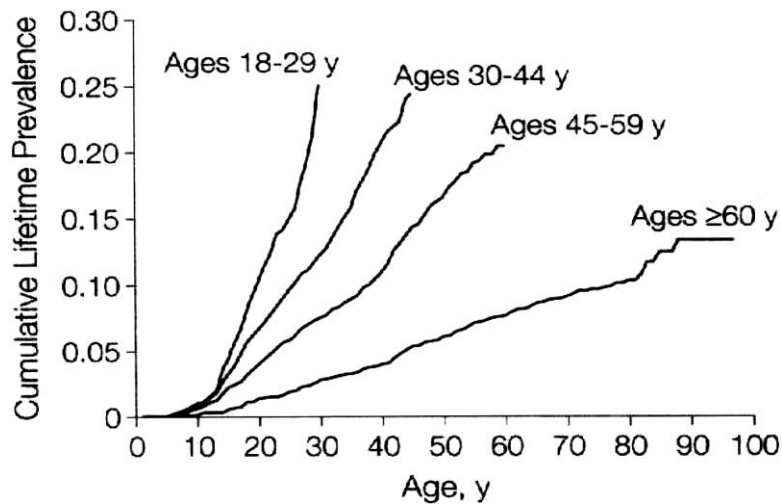

Figure 6: Lifetime prevalence of major depression among Americans, by cohort. Such surveys are flawed in charting the trends over time in depression (relying on recall of past episodes, for example), and probably exaggerate the extent of the increase in depression. Source: Kessler et al. 2003.
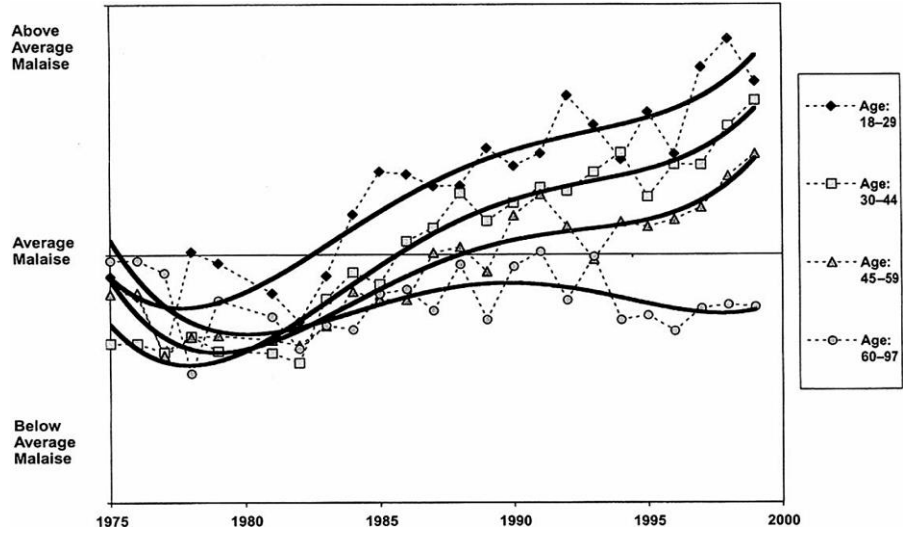
Figure 7: The growing generation gap in malaise, USA, 1975-1999. In the mid-1970s, there was little difference in malaise between age groups. Since then, the proportion of those over sixty who ranked high on symptoms of malaise has gone from 33 to 30 per cent; for those aged 18-29 the fraction rose from 31 to 45 per cent. Source: Putnam 2000: 263-5.