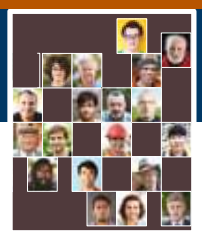


Insights into men's suicide

By **Susan Beaton MAPS**, Suicide Prevention Consultant, and **Dr Peter Forster MAPS**, University of Worcester, UK

"The breach between what we know and what we do is lethal." Professor Kay Redfield Jamison

Suicide is a considerable public health issue garnering increasing attention in public and academic dialogue over the past few years. Despite alarming statistics showing a high gender skewing towards males, there has been remarkably little focus on prevention, intervention strategies or research to address male suicide.

Men's suicide statistics

Close to 80 per cent of all suicides in Australia are men (1,816 of 2,361 in 2010) and it is the cause of death with the highest gender disparity (333 male deaths for every 100 female deaths according to the Australian Bureau of Statistics, 2012). Suicide is the number one killer of men under 44 years, with the highest death rate for males in 2010 observed in the 35 to 49 years age group (approximately 27.5 per 100,000). The next closest age group is 75 to 84 year old men (25.8 per 100,000). Although suicide of men in the 15 to 24 years age group occurs at a lower rate (13.4 per 100,000) it accounts for close to one quarter of all male deaths in this age bracket. Suicide ranks second to coronary heart disease in its contribution to potential years of life lost by Australian males (Australian Institute of Health and Welfare, 2010). [See Figure 1 below]

Reasons for gender disparity

The Interpersonal model (Joiner, 2005, 2011; Witte et al., 2012) proposes that sex differences in suicide are the result of differences in acquired capability for suicide, which is said to comprise two components: fearlessness about death and physical pain insensitivity. Higher acquired capability for suicide among men than women makes it more likely that men will kill themselves when suicide is being considered. Thwarted belongingness and perceived burdensomeness are also factors contributing to Joiner's theory and suicide risk factors for men.

Other psychological explanations for the disparity include that men have a greater tendency to not recognise or respond to their own negative emotions or distress, which may result in more chronic and severe emotional responses to adverse life events (Goldney et al., 2002). Men are less inclined to communicate feelings of despair or hopelessness, and are more likely to present a stoic attitude towards misfortune (Howerton et al., 2007; Witte et al., 2012) and have fewer social connections (Denney et al., 2009). Differences in help seeking between men and women are additional contributing factors. Men tend not to seek help for emotional difficulties, often feeling that help-seeking is a weakness or failure and preferring to solve problems on their own, without being a burden on others (Emslie et al., 2006). Compounding this is a frequent lack of awareness among men of available support services, or a sense that these services do not adequately cater for their needs and would not help in their situation (Wilson & Deane, 2010; Bruffaerts et al., 2011).

Other reasons for the relatively higher rate of suicide among Australian males are that males tend to choose more lethal methods of suicide such as hanging (60% of male suicides), poisoning, including by car exhaust (11%), and firearms (8%).

Correlates of suicide in men

Diagnosis of major depression

There is a demonstrable correlation between major depression and suicide. Some depressed men can experience avoidant, numbing and escape behaviours which can lead to aggression, violence and suicide. Gender differences appear not so much in the experience of depression, but in its expression (Brownhill et al., 2003 & 2005; Rutz & Rihmer, 2009).

Relationship breakdown

Suicide risk has been shown to be high among separated males, especially younger males aged 15-24 years (Cantor et al., 1995; Wyder, Ward & De Leo, 2009). Kolves, Ide and De Leo (2011) studied the suicidal behaviour of men who had experienced the breakdown of a marriage or de facto relationship and showed that both trait shame (pervasive, long-term feelings) and state shame (feelings related to an event) predicted suicidal behaviour. Harwood, Hawton, Hope and Jacoby (2000) observed an increase in suicide risk due to poorer social support among elderly widowed or divorced males.

Previous suicide attempts

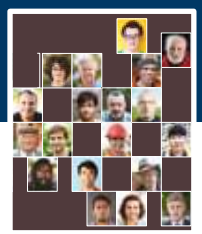
A suicide attempt is a strong predictor for suicidal behaviour (Skogman, Alsen & Ojehagen, 2004; Beghi & Rosenbaum, 2010), with suicide risk among people who self-harm being up to 200 times higher than in the general population across the lifespan (Owens et al., 2002). Being bereaved by suicide also carries an increased risk.

Alcohol use

Males are more likely than females to have been diagnosed with a substance use disorder (Schneider, 2009), particularly an alcohol-related disorder (Kim et al., 2003). A wide range of alcohol-positive cases have been found for suicide (10-69%) and non-fatal suicide attempts (10-73%) (Cherpitel et al., 2004). Alcohol has the effect of disinhibiting and triggering impulsive behaviour and exacerbates feelings of hopelessness and depression. It also impairs judgment, reality testing and problem-solving, which explains its common association with suicide. Alcohol abuse and especially increased usage are common warning signs in suicidal men.

Financial factors

Based on studies of the effects of unemployment, Gunnell, Platt and Hawton (2009) speculate that financial crises will lead to elevated levels of suicide, particularly among men. However, an Australian study by Berk, Dodd and Henry (2006) suggests that this effect may be limited to males up to the age of 34.



Employment and financial security are factors to consider for male wellbeing.

Rural location

Men living in rural and remote locations experience a higher rate of suicide than their metropolitan counterparts. Page et al. (2007) revealed that male suicides in rural areas increased from 19.2 per 100,000 during 1979-1983 to 23.8 during 1999-2003. Some of the factors implicated in this increased risk are greater access to firearms, lack of services, social isolation, traditional male stereotypes, problematic alcohol use, climatic variability and economic fluctuations.

Indigenous heritage

According to 2010 ABS data, the age-standardised death rate for suicide was 2.5 times higher for Aboriginal and Torres Strait males compared to non-Indigenous males. A recent publication on Queensland Indigenous suicide attests to a 2.3 times higher rate for Indigenous males (De Leo et al., 2011), with 74 percent between the ages of 15 and 34 years (38% for equivalent non-Indigenous data). Suicides among Indigenous men aged 15 to 24 years were four times higher than their non-Indigenous counterparts. Suicide has only been prevalent in Indigenous cultures in Australia since the 1960s and is considered to be connected with the general disenfranchisement and marginalisation of Indigenous people (Hunter & Milroy, 2006; Tatz, 2001). Indigenous males are at high risk of suicide contagion (Elliott-Farrelly, 2004; Hanssens, 2007).

Treatment and prevention

Psychologists should routinely ask about suicidal thoughts and behaviour, whatever the reason a man is seeking assistance. Research demonstrates that there are no iatrogenic effects to asking about suicide (Gould et al., 2005; Rudd et al., 2006; Mathias et al., 2012). Initial client history forms should include questions about previous suicidal behaviour and exposure to other's suicidal behaviour (especially significant people) and trauma, and these should be followed up through verbal inquiry.

Many men respond well to psychological treatments that encourage problem solving and enhance their ability to develop coping strategies and gain control over their emotions and circumstances (Emslie et al., 2006). Strong social connectedness is a protective factor worth cultivating and supporting in men. Given the increased suicide risk related to relationship breakdown, men in transition need to be supported to reach out and maintain social and family connections (Denney et al., 2009). The importance of employment and financial security cannot be understated in the lives of men. Consideration and support of these protective factors will mitigate risk for suicide and enhance wellbeing, as will frank discussion about minimising alcohol use at times of extreme stress.

The authors recommend using the 'Safety Planning' methods and tools developed by Stanley and Brown (2008; 2012) when working with suicidal men. Continuity of care is of utmost importance for suicidal clients (Knesper 2010); if referring on, consider providing follow-up call/s and/or caring postcards (Motto & Bostrom, 2001; Carter et al., 2007) to support a smooth transition and continued uptake of care.

Schaub and Williams (2007) propose that suicide prevention programs for men should draw on men's skills and strengths, rather than on perceived failings or shortcomings. It is also valuable to introduce suicide prevention programs that target the family and friends of suicidal men who do not seek help themselves (Mishara et al., 2005).

There is an emerging focus on employment status and industry impact on suicide rates and the benefits of using a workplace setting approach to men's suicide prevention. EAP providers should consider offering lunchtime presentations to all staff on topics such as stress and anger management, depression, relationship skills, conflict resolution and healthy lifestyle. Such a universal approach can build resilience and increase the likelihood of help-seeking during a crisis. Examples of successful suicide prevention programs based in a workplace setting include *Mates in Construction* (Gullestrup, Lequertier & Martin, 2011) and *Working Minds* (http://workingminds.org/).

Targeted public health campaigns include a recent innovative, US approach, www.ManTherapy.org, which uses humour to engage men's interest in help-seeking. The Australian young men's campaign, http://softenthefckup.com.au/betterifyourearound/, aims to change the focus from a short-term, problem-oriented timeframe to an extended view which encompasses future positive experiences. It remains to be seen whether such universal approaches can impact on increasing resilience, coping strategies and help-seeking and therefore suicidal behaviour.

Conclusions

To begin to understand suicide in men we need to acknowledge the psychobiological and cultural realities and demands on men's lives, as described by Ashfield (2010).

> *The practice of blaming men for 'holding in their emotions' and 'not seeking help', and calls for changes to the traditional male role, sounds plausible but is, at best, lazy and simplistic. It is a view that conveniently avoids dealing with the more complex issues of male suicide, and is one that is ignorant of biology, and offensively dismissive of the lived reality of most men's lives – what society expects of them, and what they must try to be to meet these expectations.*

Let us act on what we know with compassion, respect and hope and continue to build the knowledge base to address the huge gender disparity in suicide.

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The APS received funding from the Federal Government to develop an online Suicide Prevention Professional Development Training, which provides an excellent start to honing knowledge and skills in this area. The suggested readings can further extend competence and confidence. The program is available from www.psychology.org.au/Events/EventView.aspx?EventID=9179&Highlight=1

The list of references cited in this article can be accessed from the online version of the article (www.psychology.org.au/inpsych/2012/august/beaton/).

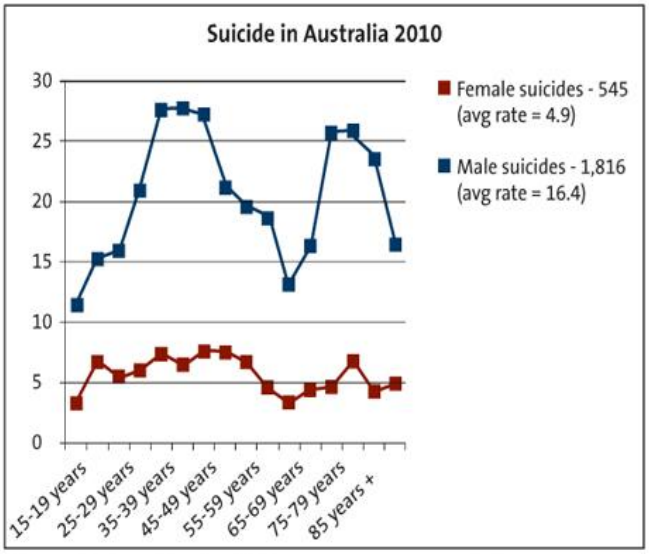

Figure 1. Male and female suicide rates per 100,000 population across age groups in 2010 (ABS, 2012)

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