MEN'S LIVED EXPERIENCE OF SUICIDE AND ITS PREVENTION

Report to the Australian Men's Health Forum

Abstract

This report highlights the findings of interviews conducted with men who have lived experience of suicide. There is a multiplicity of interconnected life situations that form a pathway to suicide. These include mental health and illness, childhood trauma, loss of employment, relationship breakdown and associated legal issues, and isolation, along with a lack of support.

Barriers to help-seeking were also identified in these interviews, particularly in relation to the stoicism of generational forms of masculinity and the inconsistent quality of health service provision. There are several implications that emerge, including the acknowledgement of suicide as more than just a mental illness, the affirmation of holistic, alternative and informal support strategies and the adoption of a whole of government approach to suicide prevention.

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Introduction

In response to the Department of Health for the National Suicide Prevention Adviser, this report presents the main findings of one-to-one interviews conducted with males with lived experience of suicide. The participants were recruited through the networks of the Australian Men's Health Forum (AMHF) and its member organisations in partnership with Western Sydney University (WSU).

Background

Despite enormous increases in funding and program activity, suicide deaths have continued to increase over the last 15 or more years in Australia. Currently, suicide is one of the leading causes of deaths in Australia amounting to more than 3318 people in 2019 at a rate of 12.9 for every 100,000 people. This is twice the rate to deaths by motor vehicle accidents[i], and much higher than deaths by homicide, which is recorded as 375 in 2018.

By these figures, Australian males are at higher risk to die of suicide than females: 2502 suicides were male and 816 were female in 2019[i]. The rate of suicide per 100,000 for males has increased over the past 10 years from 17.5 in 2010 to 19.8 in 2019. Over the same period the rate of suicide for females has increased from 5.0 to 6.3[i]. It is generally agreed that the rates are under reported by at least 20-30% in Australia[ii] [iii]. Aboriginal and Torres Strait Islander men and boys aged between 15 to 25 are at higher risk of suicide among Australians; in 2019 alone suicides among Aboriginal and Torres Strait Islanders were four times greater than non-Indigenous males. Although there is no significant difference in men and women with their experiences of mental health issues, it is important to acknowledge the findings of the research[iv] suggesting that there is up to 59% of the variance in mental health help-seeking attitudes among men. This difference is largest during adolescence; with only 13% of males with a mental health problem seeking professional help compared to 31% of females aged 16 to 24 years[v].

There is a strong need to develop male-friendly services where men feel comfortable in seeking help, a more effective approach than to continuously criticize men for so-called non-help seeking behavior. Sometimes it is helpful to think of "emotional distress" rather than mental illness by acknowledging the underlying factors contributing to suicidal ideation. These are known as the social determinants of health, and can range from an individual level to societal and cultural levels. The social factors include unemployment, underemployment, socio-economic status, relationship breakdowns, discrimination against Indigenous populations and people with diverse sexuality and culture. All can play a key role in increasing self-harm[vi].

Funding and Ethics

The Department of Health for the National Suicide Prevention Adviser commissioned AMHF to carry out this project. AMHF engaged WSU to conduct 12 interviews under the banner of

an existing research project exploring men's stories of lived experience of suicide and mental health. Ethics approval was obtained from South Western Sydney Local Health District Human Research Ethics Committee (approval number 2019/ETH12866).

Method

The research framework for this study was aligned with the Ecological model of Health designed by World Health Organisation (WHO)[vii], which focuses on influence relationships, community and societal factors along with individual factors on the health of an individual. More often there are many correlating factors rather than any single factor contributing to suicide ideation in men, which is why we have taken this multi-level approach to investigate the social determinants of suicide.

The use of 'story' as a research technique is a valid means of exploring lived experience. Narrative interventions are an emerging field with an encouraging evidence base[viii], and public narrative-sharing is a central means for promoting healthy masculinities and transforming life experience[ix]. This study covers the stories of 12 males (Age 25 – 65) with lived experience of suicide, from a range of backgrounds and life situations. The interviews were focused on the following main topic areas:

- The circumstances that contributed to the men's thoughts of suicide
- What did they do (or did others do) that helped or hindered recovery?
- What services and professionals did the men have contact with?
- What did services and professionals do that helped/hindered the men?

Interviews were held online, to make certain all participants were conversant with the formal details of the study and before each interview, the research participants were given a research protocol. This included general information about the study, assurance of the adherence to privacy and confidentiality issues, the voluntary nature of participation, request for permission to tape record the interview and a consent form for participants to sign regarding the above. After each interview, the interviewer offered participants the possibility to debrief with the interviewer or, if preferred, with a previously approved counsellor, support person or group.

Findings

The objective of this analysis was to understand the impact of major life situations or experiences leading to suicidal ideation in men. The themes identified were described according to the ecological model of violence proposed by WHO[vii] at the individual, community and relationship level (as mentioned above). The four significant factors influencing suicidal ideation were: childhood trauma, loss of employment, pending legal issues and relationship breakdown. In addition to these major situational factors were many individual and social factors such as drugs and alcohol use, bereavement, loneliness and underlying mental health issues.

Childhood trauma

There is an interplay between childhood trauma, cognitive biases, psychotic-like experiences and depression and their impact on predicting lifetime suicidal behaviour[x]. It is also noticed that traumatised children have poorer long-term outcomes than non-traumatised children.[xi] The issue of childhood sexual abuse clearly indicates that a sense of loneliness prevailed through adulthood and accumulated trauma over years resulted in loneliness and toxic relationships. One of the men said:

> *Losing my best friend and family member aggravated the trauma. It was a vicious cycle. Unfortunately, wrong diagnosis leading to time spent in psych ward further worsened the condition.*

Another participant said:

> *Childhood depression led to divorce at 27, and mid-life crisis with lack of financial stability. Over time, multiple situations created a sense of despair and incompletion leaving with a sense of total failure in life. This caused dependency and extreme loneliness.*

For another man, having suicidal tendencies since childhood eventually led him to a life of drugs and alcohol. This was further aggravated by the loss of a child resulting in depression.

Loss of employment

Employment is a significant contributor to one's wellbeing as many people define themselves by their occupation[xii]. Previous studies[xiii] have illustrated the impact of work-related stress and suicidal ideation in men. Employment or unemployment goes beyond the idea of income generation and plays a key role in organising an individual's life since it largely determines the educational opportunities, sense of identity and purpose, social contacts, and pension after the employment tenure. Once we see employment as one of the major social determinants of an individual's wellbeing, it is easy to understand the link between unemployment/underemployment and reduced mental health. The men in this study affirmed that the loss of employment and growing financial stress had a significant impact on their suicidal ideation. One man reported:

> *Losing my job in the army was just a start of my downfall, one damn thing after another. In a span of one year seven people I knew killed themselves, I was noticing these things happening around me, which pushed me to the moment of attempt.*

It is also important to note the impact of a new occupation after losing their initial well-paid job, which gave them social status and identity. For example:

Working in a café and bar after losing my job felt like I lost my status and identity, which were the major reasons for recurring suicidal ideation.

Being declared as non-competent for the job you have been doing for over a decade is so inhuman.

Financial distress after losing employment can play a pivotal role in men's mental health as one of the participants confirmed:

I began selling off some of my belongings to make my mortgage payments, which reinforced my feeling of failure and unworthiness.

Relationship Issues

Previous studies have depicted the effect of strained relationships on mental health. As per a Utah Valley University[xiv] study, suicidal tendencies result from a complex interaction of factors. The vast majority of those who attempt or die by suicide have experienced one or more major Adverse Life Events (ALE). It is important to understand the dynamics of attitude from both genders as men are typically showcased as the perpetrators of violence but the lack of attention given to male victims of domestic violence, fathers losing custody of their children after separation or men facing pressure from a previous partner to provide childcare irrespective of their financial status, are found to be the major contributors suicide ideation.

Unsuccessful relationships led to feeling of failure and unworthiness about life. This constant feeling of worthlessness resulted in a downward spiral resulting in alcohol addiction.

Another participant said:

Depression and OCD during growth years led to relationship breakdown and entangled in legal battle resulting in loss of child custody proved to be a major blow.

The positive relationship between a father and child can impact the wellbeing of both children and men in fostering a healthier community[xv]. In a similar way, losing a child can cause major depression and other mental health issues[xvi]. One survivor described the experience as:

Losing my daughter to the genetic disorder brought me the darkest days of my life, I couldn't spend time alone and was always looking for someone to be there in the same room with me.

Pending Legal issues

Associated with relationship breakdown are instances of pending legal issues, particularly in relation to custody of their children. For many there is a psychological fallout of parental alienation, not just on children but also on their parents[xvii]. As one man confirmed:

> *The death of one child and loss of another child custody resulted in a hopeless cycle of drugs, alcohol and homelessness. Situation seemed to keep going downhill with prison time and loss of business.*

For another participant:

> *Long pending case with family court and ultimate loss of child custody followed by unemployment and inability to provide for child support made life a miserable journey.*

Challenges/barriers in help seeking

Inconsistent help, fear of misdiagnosis and previous negative experience with the healthcare system seem to be major factors for men to move away from seeking help, along with other common contributing factors of self-stigma and lack of awareness. One of the men informed the study that:

> *The road to recovery seemed impossible because no one around me knew what I was experiencing. I was afraid that they will lock me up if I told someone about my feelings*

Although in some cases, it was affirmed that traditional treatment via medication for mental illness had proven helpful, the issue of systemic barriers was also a strong theme, summed up in the following comments:

> *Although the psychologist was helpful, I couldn't relate to her.*

> *The hospital people were the last group to go to when you feel suicidal as they have zero empathy.*

> *Risk of losing the job and fear of being locked up in psych ward made me live with these feeling for a long time.*

> *Mental health helplines are useful to calm the person down through the steps, but seem very robotic - lacks human empathy.*

Support Networks

The participants revealed that alternative methods of recovery such as joining a local men's group, connecting with nature and spiritual practices have helped them more than traditional medical professional help. The following are samples in their words that capture some of these ideas:

> *Connect to men's group, go out, tell your story in a safe environment. They heard me, without freaking out and calling an ambulance. I was surrounded by people who reminded me that I am doing really good.*

> *Take a walk, go down the road to have a coffee in the café to be part of the community.*

For some, hearing similar stories contributed to bringing back joy into their lives. They understood that they were not isolated cases and should stop blaming themselves for the way their lives evolved. For example:

> *Hearing other people's stories helped me to motivate, accept, forgive and move on and not give up.*

There is some evidence in the literature that connection with the environment is protective of people's mental wellbeing, and this aspect came out in the participants' stories, that nature can often have a calming effect even on the most disturbed mind, and bring some level of peace. For example, one man's recovery was aided by "reconnecting with nature via men's health retreats in the bush", while another said:

> *I am connecting with nature and learning to be a complete person without seeking someone to complete my life.*

Finally, the understanding that a suicide attempt is not the end of life but that things can be turned around, step-by-step, provided motivation. Their learning and growth as a result of their experience was evident. For example:

> *I'm grateful for the things that happened to me as this pain turned into compassion to feel the pain of others.*

> *I'm proud of myself, I realised the importance of nature and life.*

> *Take a week, write it down, so you can keep track of things and this can be given to professionals when you meet them.*

Discussion and implications of findings

It is important to acknowledge that there are a complex set of intersections between multiple life situations that are associated with suicidal ideation and suicide attempts. Childhood trauma, loss of employment, financial distress, relationship breakdown and pending legal issues were identified in these interviews, but it has also been documented elsewhere that homelessness, loss of land and livelihood in rural areas, and dispossession of land for Indigenous people are key social determinants. Often it is not just one of these determinants, but the accumulation of distress that impacts on a person's life as a pathway to suicide.

The second point to note is that, while in some cases an underlying or ongoing diagnosis of mental illness is a factor in lived experience of suicide, there are cases where men do **not** have a formal diagnosis, and some instances where men have been misdiagnosed. It is also important to draw a distinction between long-term mental illness and an acute or crisis mental health event. That is, suicide is still related to mental health, just not always with a diagnosis of mental illness. The implication is that there are multiple pathways to suicide that require strategies broader than mental health service delivery.

Thirdly, the research highlighted the inconsistent quality of health service delivery. Sometimes suicide is compounded by men not seeking help when needed, for reasons associated with fear of loss of income, stigma, fear of impact on relationships, and the proliferation of stereotypical stoic masculinity. However, there is a further issue of availability and access to male-friendly health/support services. It has also been the case that when men do seek help, they are confronted by additional barriers. For example, blame and guilt placed on men for not coming sooner, assumptions made by professionals that are perceived as 'anti-male', and an incomplete understanding of male communication styles. Services that are dominated by a medical/psychiatric model are also less well-regarded.

Additionally, it is vital to affirm the role of holistic, alternative and informal approaches to male suicide prevention. Many of these men's stories paid respect to grassroots men's support groups, informal friends and support networks, nature-based interventions, and services staffed by a broader range of professionals. Trustworthy relationships are the common factor, and these types of approaches provide significant support in recovery from a suicide attempt, and an equally important role in its prevention.

A final implication of these findings points to the importance of being able to address systemic barriers. The apparent lack of connection and communication between different branches of the health/support service system suggests that improvements in this area would be facilitated by a whole of government approach.

Recommendations:

1. That the Australian Men's Health Forum present this report to the Mental Health Commission Suicide Prevention Task Force.
2. That the Australian Men's Health Forum make this report available to research participants and update the participants with any further developments.

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