Submission to Suicide Inquiry

Social Stressors and Male Suicide
Stephen Kilkeary, Nov 09

> '*…suicide has come to be seen by the public and particularly by health professionals as primarily a matter of mental illness, perhaps compounded by biochemical factors and social stressors, the sad result of depression or other often treatable disease – a tragedy to be prevented. With the exception of debate over suicide in terminal illness, the only substantive discussions about suicide in current Western culture have concerned whether access to psychotherapy, or improved suicide-prevention programs, or more effective antidepressant medications should form the principal lines of defense*'(Battin, 2005).

Introduction

It is my intention in this submission to discuss the social stressors that can lead to male suicide and to ponder some possible solutions. But first, I want to provide a brief summary of the history and ideology of suicide prevention…

The history of the suicide prevention industry harks back to the establishment of the Samaritans in the United Kingdom in the early 1950s [www.samaritans.org]. Then, as now, suicide was a troubling phenomenon, illegal and immoral, a transgression against the will of God and punishable by the State for those attempters who survived. As with how people who were mentally unwell were treated, the service response to attempters was in part about saving lost souls and in part to punish attempters for their perceived moral turpitude. Over time, while suicide prevention has become an increasingly medicalised endeavour, the emphasis remains on stopping the afflicted individual from taking her or his own life in the crisis moment (Rogers & Soyka, 2004). Suicide is thus conceptualised as a momentary, irrational act in which any reasonable person would not ordinarily engage. I would argue that such a rationale is flawed for several important reasons, including:

1. The business of stopping someone from killing her or himself reminds me of that widely held Christian view that abortion must be opposed, without reservation. Little, if any regard is given to the toxic environment into which a child might be born. Seemingly, all that matters is ensuring that the foetus comes to term. This represents a profound ideological stance about the sanctity of life that can be dangerously ignorant of subjective reality. Similarly, with suicide prevention often all that matters is saving the life of the suicidal person. The accent is almost entirely on that particular act in that particular moment. Little, if any regard is given to the context in which that suicidal person has been struggling to eke out an existence.

2. The suicide crisis model, a subset of the crisis intervention model, assumes certain facts to be true about the subjective experiences of suicide that bear scant semblance to reality (Rogers & Soyka, 2004). For one, the term 'crisis' implies a brief moment that with appropriate support will pass. Nothing could be further from the truth. I have worked therapeutically with many suicidal men for whom their suicidal ideation was directly related to their context over the longer term. It was only when problems associated with that context were ameliorated that the suicidal ideation could pass. Further, crisis intervention imposes helplessness upon the suicidal

person at a time when that person's individual agency, strengths and resilience should be reinforced (Rogers & Soyka, 2004).

3. The suicide attempt or act is not necessarily carried out by someone who lacks rationality or capacity and who would, if stopped in the moment, prefer to keep on living. Suicide can be a perfectly logical response to untenable context-based factors such as intense physical or psychic pain, poverty, unemployment, relationship breakdown, homophobia and so forth (Schneidman, 1993, in Mills, et al., 2005). By transforming suicide into sickness and incorporating it within the biomedical domain, that plethora of causative factors is replaced by the sheer folly of trying to identify those mentally unwell people who are at risk of committing suicide.

Male suicide equals mental disorder

I would argue that the greatest and most persistent myth about male suicide is that it is the product of mental disorder and therein, a discrete form of gendered depression (Moller-Leimkuhler, 2003). This grand hypothesis is at best patchy, inconsistent and lacking in empirical evidence (Rabinowitz & Cochran, 2008). It was Rutz, et al. (1995) who first proposed the concept of 'male depressive syndrome' to describe symptoms that included 'low stress intolerance, acting-out behaviour, low impulse control, substance abuse and suicide' (Brownhill, et al., 2005). In effect, they contend that men experience depression differently to women and as a consequence, their depression is more likely to remain hidden or unnoticed (Brownhill, et al., 2005). The challenge, therefore, becomes threefold:

1. To get men to recognise that they are depressed;
2. To get men to seek medical help for their depression; and
3. To skill-up gatekeepers to assist men in that process.

To accept this hypothesis is to accept that depression is the sole or dominant precursor to suicide when, as I will discuss shortly, suicide has multiple causative pathways (Rosenman, 1998). If you attempt to build a theory on a faulty premise then all that follows will also be faulty. And that is how the theory of male depressive syndrome as the explanatory paradigm for the exponentially higher rate of suicide in men, as compared to women, has emerged (Brownhill, et al., 2005). In fact, the two are so often spoken about interchangeably as to infer a robust, positive correlation. Little wonder then that in recent years, suicide prevention theory and practice has increasingly emphasised the core task of getting men into clinical treatment for their hidden depression (Rochlen, et al., 2009).

The primary evidence for the purported positive correlation between male depressive syndrome and male suicide starts with the claim that anti-depressants decrease suicidal behaviours (Tamas, 2005; Levin, 2008). While sometimes this is true, equally, sometimes it is not. For example, two studies published in Great Britain in 2008, clearly demonstrated no significant correlation between suicide rates and prescribing trends (Levin, 2008). Moreover, since the vast majority of men who are depressed never attempt or commit suicide, this type of data is almost certainly drawn from a small, skewed subset. And, as Nock, et al. (2009) discovered in their cross-national analysis of the association between mental disorders and suicidal behaviour, depression is not even strong predictor for suicide:

'…although depression has repeatedly been shown to be among the strongest predictors of suicide attempts and was similarly predictive in the current study, decomposition of this association revealed that it is due largely to depression

predicting the onset of suicide ideation. A diagnosis of major depression is much less useful in predicting which people with suicide ideation go on to make suicide plans or attempts, and it is non-significantly associated with unplanned attempts in both developed and developing countries. In contrast, disorders characterized by anxiety (especially PTSD) and poor impulse control (especially bipolar, conduct, and substance use disorders) emerged as the strongest predictors of which ideators make suicide plans and attempts, and were especially useful in the prediction of unplanned attempts'.

The important consideration in the above findings is not that suicidal ideation can best be attributed to anxiety disorders or disorders affecting impulse control but rather, the actual behaviours themselves: anxiety and poor impulse control (Nock, et al. 2009). While suicide prevention researchers working within a biomedical framework will invariably try to squeeze these behaviours into one or more specific mental disorder categories, in reality there is no corresponding neatness of fit. Suicidal ideation in men is way too scattered and subjective for such naive reductionism. Most significantly, anxiety and poor impulse control are typical behaviours associated with trauma and trauma, unlike mental disorder, is firmly grounded in context (van der Hart, et al., 2006) The elephant in the room that few within the suicide prevention industry in Australia would dare to name is that male suicide is seldom caused by individual pathology but more usually by one or more social stressors (Page, et al., 2006). That raises the unpleasant prospect that suicidal causation is external to the individual.

<u>What do we know about male suicide?</u>

1. Male suicide has multiple causative pathways

'No single predictor or combination of predictors is present in every individual, and membership of the high-risk group changes from moment to moment. Half a bottle of whisky may create a high suicide risk within half an hour' (Rosenman, 1998).

The psychiatrist, Stephen Rosenman (1998) once remarked that trying to pin down suicide causation was like trying to find a needle in a haystack. It is nigh on impossible to extrapolate the pre-determined characteristics of a specific high-risk group to the extraordinarily subjective experiences of individuals who might be contemplating or acting on their suicidal thoughts. Substance misuse, unsafe sex, violence and aggression are amongst many other causative factors which alone and together, in a myriad of combinations, make accurate prediction a fruitless endeavour (Sher, 2006; Tamas, 2005; Plumb & Brawer, 2006). And yet, despite the utter implausibility of trying to identify the solitary suicidal male in the general population, from a prescribed hierarchy of risk factors, this quest remains the holy crusade of the suicide prevention industry in Australia.

2. Suicide is a predominantly male phenomenon

Like most Western countries, women in Australia attempt suicide more often than men, although men complete suicide here at a rate four times greater than women (ABS, 2009; Rochlen, et al., 2009). This enormous, gendered disparity has been relatively fixed over the past 50 years or so, with the exception of the 'spike' in the female suicide rate at the time of the 'benzo'(diazepine) epidemic in the late 1960s, which particularly impacted upon women. I have already indicated that to try and explain away this disparity as the product of male depressive syndrome is absurd. A

more critically reflective analysis reveals that there are key factors peculiar to how masculinity is constructed in Australia which in large measure make sense of why men become so much more 'efficient' than women at completing suicide. I will refer to some of these key factors, shortly.

3. Male suicide is not the product of any alleged 'crisis' in masculinity

There has been much confusion over and trepidation by the suicide prevention industry in Australia with respect to how to adequately respond to the persistent problem of male suicide. The cavalcade of men's sheds, blokey language and blue-collar stereotypes of masculinity all suggest that a return to the mythical 1950s, when men were men and knew who they were, is the solution (Moller-Leimkuhler, 2003). Connell (2008) has observed an equally disturbing trend in boys' education policy in Australia, with an ascendant 'boys as victims discourse' that seeks to promote an 'essentialist view of gender' in which the naturalness of what constitutes femininity and masculinity is presumed. However, as Gosine (2007) has noted, there is no 'crisis' in masculinity and so there can be no positive association between something that does not exist and male suicide.

4. Male suicide afflicts certain men in particular contexts

Male suicide does not affect all men equally but instead, affects certain men in specific contexts in particular. For example, Page, et al. (2006) found that while there has been a downward trend in the overall suicide rate for young men in Australia, for young men from low socio-economic backgrounds, the suicide rate is actually increasing. Moreover, young gay men are much more likely to attempt suicide than their straight counterparts, a tragedy that is directly linked to the high incidence of homophobia in Australia (Dyson, et al., 2003; Hillier, et al., 2005). It is stunning policy hypocrisy that the same Christian organisations that governments fund to provide suicide prevention services aggressively perpetrate hatred toward gay men. I know of gay men who have been suicidal and who have contacted such organisations for support, only to be abused because of their 'depraved' lifestyles.

How do we 'cure' male suicide?

From my therapeutic experience working with suicidal men, from my research on men's mental health and from my own personal experience of suicide, it is my considered view that the first step in curing male suicide is to accept that it is not a disease in search of a cure. Rather, it is a complex array of context-based factors that intermingle with subjective and inter-subjective experiences. I can well understand the purpose of trying to dumb suicide prevention down to fit within a uni-dimensional, biomedical model. Simplicity always makes more sense than complexity. Besides, that model offers a 'no blame' alternative to asking tough questions like:

- does poverty lead to male suicide?
- does child abuse lead to male suicide?
- does hegemonic masculinity lead to male suicide?

I would contend that the missing piece in men's health policy in Australia is an understanding of and appreciation for the centrality of primary prevention. Beyond the practical steps that can be taken to limit suicide attempts, such as restricting access to

firearms, jumping points and certain over-the-counter and prescription medications, for example, paracetamol, the only substantive way to address male suicide is to shift policy away from how to stop men from killing themselves to how to start assisting them in living well. Through whole population and targeted approaches, the physical and emotional wellbeing of men needs to be promoted across the lifespan. That would incorporate elements such as:

1. Taking steps to redress the social stressors that exacerbate male suicide

For example, there is substantial evidence supporting the links between youth unemployment in poorer areas of Australia and high rates of male suicide (Page, et al., 2006). I recall living in Newcastle during the late 1980s, at a time of severe economic downturn for that long-suffering city. It was commonplace for teenage boys and young men to take their own lives, shut out as many of them were from the steady blue collar jobs that had sustained their families for generations. A parallel situation had occurred in Scotland, where for decades youth unemployment and male suicide were much higher in poorer parts of their major cities (Boyle, et al., 2005). Sadly, it was only when the evidence became ever so overwhelming that the Scottish government began to take this sobering reality seriously (McClean, et al., 2008).

2. Recognising the deadly impact of hegemonic masculinity

'*…there is a growing research literature that links culturally dominant forms of masculinity with poor health and, particularly, with an unwillingness to seek help with health problems. This type of explanation links men's higher mortality rates to the social construction of masculinity in Western societies which requires that men, if they are to be 'real' men, take risks which may be detrimental to their health*'(Charles & Walters, 2008).

From constricted help-seeking behaviours to emphatic suicide attempts, hegemonic masculinity in Australia compels a strict code of masculine ideals that are contrary to the wellbeing of men (Connell, 2005). Not only are men in this country supposed to be strong, silent and invulnerable, they must exist within a culture of perpetual violence. That is, they must always be ready to be aggressive or to defend themselves against aggression (Rochlen, et al., 2009). Obviously, this bleak reality has more resonance for men in particular contexts, for example, those in rural, regional and remote parts of Australia (Alston & Kent, 2008). While there has been an ongoing dialogue in the media about the transformation of masculine ideals to encompass kinder, gentler, more emotional aspects, this transformation has yet to materialise (Daily Telegraph, 16 October 2009).

It is a salient point that boys are born with as much potential for emotional expressivity as girls, but even before they make it to kindergarten they have already been taught and have learnt to suck it all in (Pollack, 1998). 'Big boys don't cry'. We all know that. We all learn that script. It becomes an interaction ritual that plagues men throughout their lives, the expectation of how they should behave and the expectation of how others think they should behave. From a therapeutic point of view, suppressing emotionality in boys and men is akin to emotional distancing. I would suggest that this culturally bound practice, which starts at the moment of birth for many male children, often leads to disrupted or estranged attachment,

which in turn can lead to lifelong problems with fear, anxiety, agitation and abandonment (Pollack, 1998).

'*Little boys are made to feel ashamed of their feelings, guilty especially about feelings of weakness, vulnerability, fear, and despair. The use of shame to control boys is pervasive; boys are made to feel shame over and over in the course of growing up, what Pollack (1998) calls 'shame-hardening process'. The idea that a boy needs to be disciplined, toughened up, made to act like a 'real man', be independent, keep the emotions in check. A boy is told that 'big boys don't cry,' that he shouldn't be 'a mama's boy.' If these things aren't said directly, these messages domin[ate] in subtle ways how boys are treated- and therefore how boys come to think of themselves. Shame is at the heart of how society traumatically pushes the agenda of the ideology of masculinity (Pollack, 1998)*' (Mejia, 2005).

3. Providing appropriate care and support services for men in distress

Mental health service delivery in Australia has changed little since Erving Goffman (1961) made reference to the garage model of institutional care nearly 50 years ago, which likens the interaction between patient and service to tinkering with a broken down car. I have worked in public hospital and community mental health settings in New South Wales and I have witnessed how acutely mentally unwell men have been pushed through an assembly line process that relies far too heavily on psychoactive medication as the sole form of treatment, where discharge planning is poor or non-existent and where the precipitating contextual factors that contributed toward landing the patient in hospital in the first place are rarely, if ever adequately addressed. It is therefore not surprising to learn that psychiatric hospitalisation tends to markedly increase the likelihood that men who come into hospital suicidal will, upon discharge, complete that suicidal act (Qin & Nordentoft, 2005).

While the 'Better Access' scheme effectively provides subsidised counselling for some men, it remains time-limited and even with the Medicare rebate, in many instances prohibitively expensive. In contrast, Ireland has the National Counselling Service [www.hse-ncs.ie/en/], England the trauma counselling service attached to the Maudsley Hospital [www.slam.nhs.uk] and in the United States, there is Bessel van Der Kolk's groundbreaking Trauma Centre [www.traumacenter.org]. All of these counselling services are best practice examples, evidence-based, clinically sound and accessible, barring the high cost associated with the last mentioned service. In Australia, the provision of appropriate care and support services for men in distress veers from informal and untested sounding boards (that is, men's sheds) to purely clinical (pharmaceutical) services that eschew a therapeutic component. I should add that the much vaunted proposition that 'talking helps' is incorrect, since unless genuine, sustained solutions to the problems at hand occur, talking usually worsens the person's emotional state.

Conclusion

I know from my own personal and professional experiences that suicide is a profoundly traumatic event. The loss of a loved one in tragic circumstances can never be easy to bear and our natural inclination as humans, of course, is to preserve life. However, in that quest to preserve life we must ask ourselves some pertinent questions:

- What we are doing?
- How are we doing it?
- And what could we do differently?

I have worked therapeutically with many men whose lives, whose core sense of being have been dented, damaged, even shattered by the horrors of war, child abuse, sexual assault, homophobia, repressed sexuality, relationship disintegration and substance misuse. It would have been reductionist on my part to assign causation for the immense suffering that these gentlemen were experiencing to mental disorder categories, when the utility value of such a practice is zero. Men who are traumatised, men who are suicidal need holistic, flexible service responses. They need attention paid to their emotional as well as their practical problems. Above and beyond all other considerations, we must prevent men from ever being so badly knocked around.

> '*Being a man entails being tough, never crying when hurt, standing up for yourself, giving as good as you get, never admitting to fear, sympathy or sensitivity, and never flinching at pain or hardship*' (Stanko, 1994, cited in Evans & Wallace, 2008).

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