



Pathways to Despair: The Social Determinants of male suicide (aged 25-44), Central Coast, NSW



Men's Health Information
and Resource Centre

University of Western Sydney

MHIRC Paper no. 2

**Pathways to Despair: the social determinants of male suicide (aged 25-44),
Central Coast, NSW.**

A study of the relevance of the context of male suicide: the accounts of selected men who attempted death by suicide and members of families and friends who have lost men close to them from death by suicide.

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MHIRC works with an understanding that health is a dynamic state involving the interaction of the whole person with their physical and social environment. MHIRC's aim is to promote the health and wellbeing of men and boys, in particular those men and boys most marginalised and most at risk of poor health outcomes.

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FOREWORD

The National Forum on Men and Suicide held on May 2nd and 3rd 2006 in Sydney, marked a watershed in Australian population health, one perhaps yet to be sufficiently acknowledged (National Forum on Men & Suicide, 2006). Suicide is a tragedy for any family, any society. Australia was admirably mobilised for some years on the issue of youth suicide and, thankfully, the incidence of this phenomenon has decreased. For the last few years, however, the evidence has shown that the demographic most at risk of suicide has been men: older men and men from their 20s up to 50. The age grouping men 25-44 of the title has been chosen because it relates to the often used grouping from the ABS. One of the subjects in our study was aged 21/22. We have chosen to include this person as we believe that in reality the issues for men in the 20s, 30s and 40s are essentially the same as for the slightly smaller 25-44 grouping and the responses to the interview by this particular Family / Support persons were consistent with the other Family / Support persons interviewees.

Suicide is a gendered phenomenon. At least 5 men a day kill themselves in Australia; for some reason this tragedy has not taken hold of the nation's attention to any large extent. As has been pointed out: five dead *whales* a day (as opposed to five *males*) might perhaps raise more concern and sympathy. The Forum on Male Suicide, a gathering of more than eighty concerned persons from all over the country, was co-sponsored by Suicide Prevention Australia and Mensline Australia. In addition to attempting to put the issue of male suicide on the national agenda, the Forum also served to highlight the fact that not all suicides can be attributed to "mental health" problems. Much of the causality lies in social, economic and cultural factors. What the sympathetic study of Creative Ministries in Victoria has said of job-related suicides has relevance to many other contributory factors:

There has been a tendency to assume suicide is caused by mental illness, without adequate attention to the role of work factors in the onset of mental illness, or the interaction between work factors and a person's mental health state in the development of suicidal thoughts and action[1, p20].

When non mental health factors have been considered in the past in relation to men and suicide, the emphasis has often been on "masculinity", taken to mean (on a somewhat shaky evidence base) some learned cultural deficiencies in men [2, 3]. Both this "explanation" and the relegation of the tragedy to the "mental health" domain have "allowed" us to avoid issues in our society which impact both negatively and positively on the hold men have on life. These issues often include a feeling by men that they are valued (or not), in their relationships (for example, with men's contact with their children after separation), their job situation, as well as their experience of violence. The role of these social factors

was been pointed out at the Australian National Forum on Male Suicide (see: <http://mensline.simplenet.com.au/Upload/Docs/17.pdf>). It is for these reasons this report is called “Pathways to Despair” since it is felt that words like “depression” can tend to medicalize and pathologise perfectly understandable feelings of suffering.

Internationally, there has been an upsurge of research into the social determinants of health. This offers a whole of population perspective and is potentially of great benefit to men’s health studies and, in particular, the study of male suicide. In the present case, the Men’s Health Information & Resource Centre (MHIRC) has been privileged to work with colleagues from the Suicide Safety Network of the Central Coast of NSW and the Northern Sydney Central Coast Area Health Service) which has a long history of dealing with suicide, including male suicide, attempting to bring to society’s attention the role of some of what we are calling the social determinants of male suicide. It is to be hoped that this present study, undertaken in collaboration with them, will contribute to the culture of our society by insisting that such factors be taken seriously, with a consequent effect on service provision. The study also forms the basis for on-going, more quantitative and qualitative studies of the same phenomenon.

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1 STUDY BACKGROUND

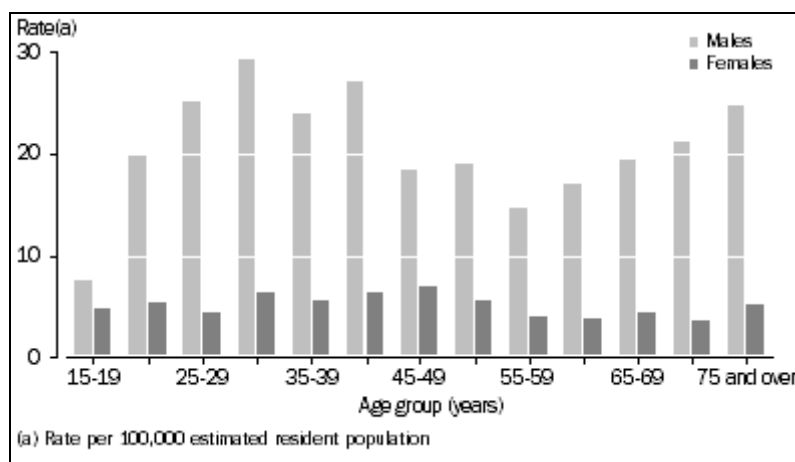
1.1 Introduction

This report presents the main findings of focus group interviews and one-to-one interviews conducted with male suicide attempters as well as with families and friends who have lost male relatives or friends through suicide. The location is the Central Coast of New South Wales. Participants were selected from a group of suicide attempters and families who were connected with the Central Coast Suicide Safety Network.

1.2 Suicide issues

Suicide in men is a major public health issue in Australia. There were 2,098 deaths from suicide registered in Australia in 2005, nearly 80 percent of them men[4]. Of these, the highest proportion of male suicides (and indeed all suicides) was in the age group 25 to 44, as shown in Figure 1.

Figure 1. Age-specific suicide rates 2005



Source: [4]

Participants in this study were selected from the Central Coast of New South Wales, about 90 kilometres north of Sydney. This includes the city of Gosford and its surroundings, and the Wyong Shire.

The Central Coast is reported to have a higher than average number of deaths of men from suicide[5]. There were 373 deaths from suicide (both men and women) on the Central Coast between 1995 and 2003 (Table 1). 77.5 percent of all deaths were men (Table 2) and 45.3 percent of all suicides among men and women were aged between 25 and 44[5].

Table 1: Age breakdown of all suicide deaths on the Central Coast from 1995 to 2003

Age Groups	1995	1996	1997	1998	1999	2000	2001	2002	2003	TOTAL
0-14yrs										
15-24yrs	2	9	9	5	7	8	7	9	8	64
25-44yrs	14	19	26	23	20	19	16	20	12	169
45-64yrs	7	10	12	17	7	4	8	9	11	85
65+yrs	4	11	5	6	3	7	5	8	6	55
TOTAL	27	49	52	51	37	38	36	46	37	373

Source: Bauer (2004)

Table 2: Gender breakdown of suicide death on the Central Coast 1995 to 2003

Age Groups	1995	1996	1997	1998	1999	2000	2001	2002	2003	TOTAL
Male	20	42	40	43	28	31	32	28	25	289
Female	7	6	14	8	9	7	4	18	12	85
TOTAL	27	49	52	51	37	38	36	46	37	374

Source: Bauer (2004)

(Note: The slightly different totals have to do with delayed coronial determinations (e.g. impending inquests))

1.3 Funding

The University of Western Sydney provided the research funds to carry out the project and ethics approval was obtained from the university.

1.4 Partners

The study was undertaken in collaboration with the Health Promotion Unit (Central Coast) of the Central Coast Northern Sydney Area Health Service (NSW Health) and the Suicide Safety Network (Central Coast) Inc. (SSN). The SSN has been dealing with suicide issues in the Central Coast communities since the mid 1990s. Very importantly, the network has included the Coroner's office at Gosford as an active partner in their work and this has allowed the network, and so this study, to have accurate data on local suicides thereby benefiting from more specific detail about suicide deaths than is generally the case. The work of these organisations had convinced them of the centrality of context and this led them to partner with MHIRC to explore these issues more systematically.

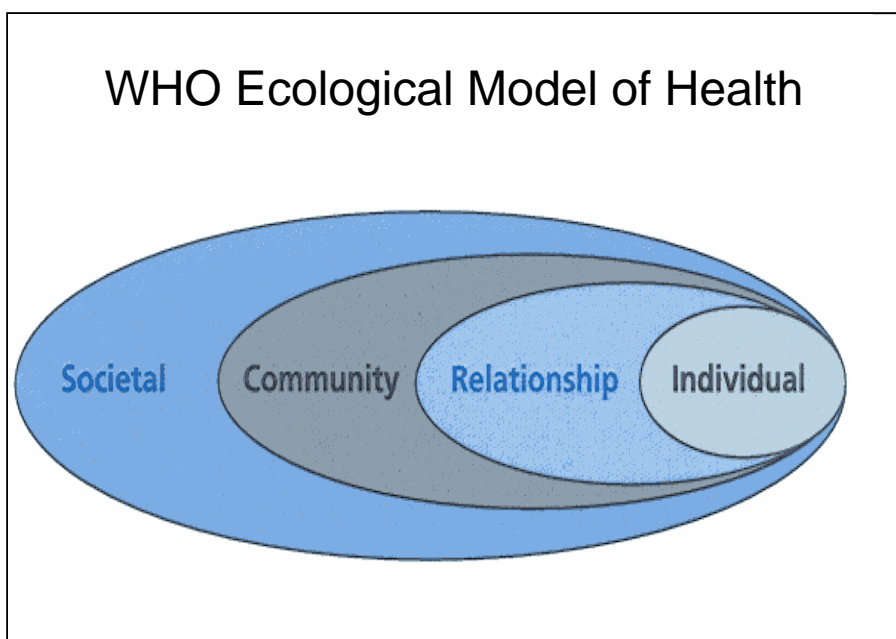
1.5 Research framework and aim

This project looks at the issue of violence in the perspective of the World Health Organisation's document, *Violence as a Public Health Issue*[6] which adopts an ecological perspective on all violence, including self-inflicted violence/suicide. The ecological perspective can be seen to be consistent with the social determinants of health and illness research[7-9]. This research highlights the importance of the context of people's lives and how these (their social, economic and emotional environments), influence their health. In this way, the study adopts what can be called a *social determinants of suicide* framework.

It investigates the pathways to despair and suicide in the lives of a number of men aged 25-44, that is to say those factors which may have contributed to their diminished sense of self worth and general state of mind prior to the incidents in which they attempted and in some cases, succeeded, to kill themselves. Often there is not one single factor at play, rather, several factors interacting on each other which put men of this age group at risk of suicide. This is why we can talk of a multi-level approach to our understanding of suicide in this population.

The WHO ecological model is a multi-level approach that includes four levels: the individual, relationship, the community and the societal[6] as is shown in the Figure 2.

Figure 2. WHO Ecological Model of Health



Source: WHO(2004)[6]

This study covers stories of the male survivors of suicide attempts, and from families and friends of suicide victims. It entails a qualitative study of 18 people comprising five men aged 25 to 45 years who attempted suicide and 13 support people who were themselves bereaved by deaths from the suicide of male friends or relatives. Qualitative studies such as this one cannot lay claim to generalisations but it is of some interest that a useful and respected study of service provision in response to suicide in the USA had a smaller sample of eight respondents[10].

1.6 Method

The following four topic areas were drawn from the work of colleagues on the Central Coast. This work included a detailed semi-structured telephone survey where data was gathered from almost 100 (mostly male) respondents from interviews using a semi-structured process[11]. These topic areas or themes were used as a guide for generating discussions in the interviews in this study.

1. What factors/issues might have helped or hindered the respondents to be positive about their psycho-social health?

From the preliminary work it was considered that the following factors were likely to be relevant:

- Boyhood experiences and upbringing
 - School/education related experiences
 - Work place issues/factors
 - Relationship with partners, parents, children, friends and any other significant people
 - Financial matters
 - The expectations laid upon them as men in their own community.
2. Their ability to manage distress – what/who helped, what did not help and how are they coping now?
 3. What local services they turned to in order to deal with their stress; what helped, what did not help; what do families and friends feel needs to be improved to obtain better services from service providers; did they experience services as being male-friendly?
 4. Beyond providing help to individuals, what can be considered to be some of the broader social and political issues which need to be addressed in order to help reduce the incidence and severity of personal distress in men?

In the present study, eighteen interviewees, including five male attempters of suicide and thirteen family and friends of men who had taken their lives, were invited to participate in either a one-to-one or group interview. All of the men who had attempted suicide (attempters) as well as some individual family members of men who had taken their own life, participated in one-to-one interviews. Group interviews took place when there was more than one family member or friend. Because of the sensitivity of the topic, it was crucial for participants to feel safe and at ease enough to open up about their experiences with suicide; to meet this requirement, the interviewer needed to be a person of high integrity, compassionate and insightful into aspects of people's experiences of suicide. The appointed interviewer not only had many years of experience in counselling those affected by suicide (in some cases as the court appointed counsellor), but also had lived on the Central Coast of NSW for many years and

commanded respect for his work with people affected by suicide in the local area. He also received training in interview techniques.

The interviews were held in a comfortable and enclosed area to ensure privacy and confidentiality to facilitate a relaxed atmosphere where participants felt safe, at ease and able to open up when recounting their stories. To make certain all participants were conversant with the formal details of the study, 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. This complied with the institutional ethics clearance.

After each interview, the interviewer offered participants the possibility to debrief with the interviewer or, if preferred, with a previously approved counsellor.

1.7 Data Analysis

In a small-scale qualitative study such as this, it is not only possible for the researchers to become familiar with each participant's story but necessary in order to reach some understanding of the complex nature of their stories, stories that benefit by being unravelled to uncover the many pathways and connectedness of these pathways that lead to despair, suicide but thankfully, sometimes, to hope. The unravelling of the stories involved a rigorous, enlightening and time-consuming analysis. To begin this process, one of the three researchers involved in this study, transcribed each interview, and to de-identify the data, omitted the names of people and places. Each researcher then read a selected transcript in isolation, and then the group re-read that transcript together. This process was repeated for each of the interview transcripts. Sentence by sentence, the transcript was deconstructed for content that was related to and of interest to the study. Because of this lengthy process, not only did the researchers become familiar with the anonymous data but also began to recognise common themes within and among the participants' stories.

To assist in the analysis and organisation of the rich data, the researchers used NVivo, a qualitative text-based analysing software package. The advantages of Nvivo are that it assists in organising and shaping the data into meaningful themes and allows easy access to the original text to verify data. This opens up opportunities for the researchers to see the data in bigger and smaller formats. For example, it became evident early in the analysis that the two different groups (the attempters group and the family or friends of suicide victims group) had, predictably, similarities but also differences. The researchers developed and compared the similarities and differences. During the group meetings of the data analysis, the researchers jointly decided how to code the interesting and relevant parts of the interview

text. After achieving consensus on the themes, they revisited the text allocated to that theme or node for contextual clarification. The data processing greatly assisted the orderly evolution from *emerging themes* to *nodes* and, eventually, to *reports*. This rigorous process was lengthy but contributed greatly to the validity and reliability of the findings.

Table 3. Demographic characteristics of participants

Interview Number	Demographics of attempters as identified in transcripts
No. 1	37 years old; moved from a neighbouring country; attempted suicide at age 23; has a daughter and a younger brother
No. 10	45 years old; attempted at age 43/44; one attempt by hanging; three children from different relationships
No. 11	In mid-20s; first attempt at age 17; made three attempts (cutting wrists, carbon monoxide poisoning and drug overdose); no children
No. 12	Aged 28; first attempt at age 20; attempted twice (drug overdose and jumped off a bridge resulting in severe injuries); one daughter and one younger sister
No. 13	Aged 33; one attempt with alcohol poisoning; moved from a neighbouring country; one younger brother

Table 4. Demographics of suicide victims as identified by family/support people

Interview Number	Demographics of attempters as identified in transcripts
No. 2	Three persons, whose friend died of suicide, participated in the focus group interview.
No. 3	The interviewee is a sister of the deceased who attempted suicide several times before succeeding by jumping off a bridge; the victim was aged in his mid-20s.
No. 4	The interviewee was a brother of the deceased; the victim was aged 34.
No. 6	The interviewee was the wife of the deceased; the victim was aged 55
No. 7	Both parents of the deceased who hanged himself when he was in his late 20s.
No. 8	Both parents of the deceased who hanged himself aged 21/22 years.
No. 9	Parents and uncle of the deceased who died in a deliberate car crash when he was 21 years.

1.8 Results from analysis of data

The object of this analysis was to gain some insights into the pathways travelled by men which can lead them to the tragic act of suicide. The *ecological* model of violence (including self-inflicted violence) as described by WHO (2004)[6] was taken as an overall explanatory framework to help illuminate the experiences of despair and suicide of the subjects under study.

Patterns were identified from the data. These patterns emerged during the analysis and were allocated into nodes that provided a centering point to highlight the interplay of factors among and between the levels of the WHO ecological model.

1.8.1 The accounts of attempters

The most significant nodes (based on frequency and the extent of the participants' experiences) which emerged from the data of suicide attempters are shown below. However, there were other nodes identified (e.g. social connections, personal characteristics) that contributed to the risk of suicide. Strong connections were found among most nodes but the ones which were most inter-connected are those shown below. The relevant WHO ecological model levels (see above) are shown in parentheses.

- Work-related issues (community level)
- Drug/alcohol abuse (individual level)
- Psycho-social health (individual/societal level)
- Adverse childhood experiences (individual level)
- Relationship strain (relationship level)

1.8.2 The accounts of family/support persons

The most significant nodes to emerge from data of those who lost a male family member or friend through suicide are:

- Drug/alcohol abuse (individual level)
- Work-related issues (community level)
- Relationship strain (relationship level)
- Dissatisfaction with mental health services (societal)

Each one of these factors is important in itself, but it would seem to be the cumulative effect of several factors which is significant in terms of the "pathways" to self-destruction followed by the participants. The narratives in this study show with terrible predictability the effect of the combination of these factors. They are a good warning for that often it would be unwise to look for a "specific aetiology" – some one causal factor. Rather, it is the "messy" interplay of the factors identified in the research which has to be understood.

2 ACCOUNTS OF SUICIDE AND ATTEMPTED SUICIDE

2.1 Accounts of men who had attempted suicide

2.1.1 Drug and alcohol abuse

This issue provides a good example of the interplay between the various factors: clearly, for example, relationship strain led some of the respondents to seek refuge in alcohol and drugs and, of course, inversely, substance abuse often impacted negatively on other dimensions of people's lives, such as their work situation or relationships. Talking of reflection on relationship difficulties, one participant said:

...it opened up all my childhood stuff so then all the resentment started and the anger came back again and then the drinking and the drugging, probably more the drugging because the drinking wasn't working for me." "...and the only way that I knew to deal with problems was with drugs and alcohol.

It is clear from the transcripts that for a significant number, the substance abuse was a way of "coping" or rather avoiding the difficulties in their lives:

Running away. Which was what I was doing with the booze as well. Got back into the drink quite severely as you know and that led to a major incident two weeks ago.

Talking of his relationship, another respondent said:

I was quite a different person. I don't think I was a very enjoyable person to be with a fair bit of the time, I was very withdrawn and wasn't very conversational, we didn't really communicate all that much even though she probably tried to communicate with me a lot but I probably pushed her away a lot of the time too when I was stoned and yeah probably just went into my own little world a lot of the time.

"Depression" is used in a lay sense by some people in the study to convey a sense of feeling very bad, and should therefore not be taken to mean clinical depression, properly so called. It is, however, fair to say that for some, the substance abuse was a way of masking difficult feelings:

This sort of elaborated into depression and slowly but surely the alcohol didn't come once a month it became once a week and by the age of 14/15 I was heavily drinking.

Sometimes the substance dependence was so pronounced it became the dominant factor in people's lives prior to the suicide attempt(s):

By that stage I had to get drunk to go get drunk. I literally could not function without the need for alcohol. And I'd learnt the theory to blacking out.

Work-related factors will be dealt with separately, but again, there is sometimes interplay: one respondent was doing “well” at work, involving him taking many people to lunch, drinks provided:

...and then probably bat on to dinner so alcohol consumption was huge, business was happening, you know. There you go. Alcoholism was well and truly under way.

It is clear from the transcripts that both the substance abuse and the risk of suicide itself are highly dependent on the *context* of the respondents’ lives in all their complexities. This may seem obvious, but the acknowledgement of this complex interplay of contextual factors ensures that one should avoid simplistic “explanations” along the lines of: “He had an alcohol problem”.

2.1.2 Work-related experiences

Work-related issues have been identified as having a significant impact, either positively or negatively, on the mental well-being of the participants in the study. This corresponds to the findings of other studies [1, 12]; as well as to the general literature on work as a significant social determinant of health. Marmot and his colleagues have highlighted the significance of work as a social determinant: *Work is the origin of many important determinants of health. Work can provide financial security, social status, personal development, social relations, and self-esteem and protection from physical and psychosocial hazards* as well as being a locus of serious mental health stress: *Stress at work, defined as a combination of high psychological demands and low control or as an imbalance between effort and reward, is associated with a 50% excess risk of coronary heart disease and other indicators of mental and physical ill health*[9]. An adverse psychosocial context in one’s working environment can affect self-esteem and cause long lasting stress. The study asked respondents to reflect on their work experience.

One survivor had a high pressure job as a car salesman. As his business expanded, he became more involved with car brokers. This meant more time out with them over lunches and drinks. He admitted to his becoming addicted to alcohol. The link for one respondent between his substance abuse and his “success” at work (taking people out to long lunches with alcohol) has already been mentioned.

Other accounts show that there can be a slow build up of bad feelings, in this case about the work situation:

I had a few of those feelings when I was putting together the plan for the grader which faded I guess when I got the bad decisions over the few times that we got sort of declined for the loan. I sort of slowly started to deteriorate again [chuckles].

Some attempters showed a low level of satisfaction in their work and others an inability to hold on to steady employment. In one case, the man managed to hold down a job by working more hours in order to support his alcohol addiction. Another was very positive about his early work experiences, but in later

years began to feel dissatisfaction when he joined the family business, involving a sense of less control over his work situation: his brother had been put in charge of the business by their parents without consulting him, resulting in considerable strain in their relationship and also a drop in earnings for him. As part of a “bundle” of hard experiences this had a strong negative influence on his sense of wellbeing.

2.1.3 Psycho-social health

This category is intended to cover what the respondents described as having to do with “mental health”. The interviews with the attempters regularly point to the fact that their mental well-being had been severely threatened as a result of childhood and adult life experiences. For example, one participant was reported to having been diagnosed with a mental illness, another with depression. For another, his report of low self-esteem accompanied by sadness gives some indication of his low level of mental well-being:

Sadness. Not really knowing that I was worth anything. I didn't really feel like I was worth anything. I didn't feel like I was going to get anywhere in life.

Clearly, this feeling links with what has been said about the importance for health of feeling valued and valuable. Again, the negative build up can be slow: sometimes this sense of low self-worth is a constant in life:

I still have wonders about what life's really about; probably think about whether life's really worth it - still think about that once a day.

It is often said that men have difficulty in being able to express their feelings or to find counselling type service appropriate to them[8]. This came up in the narratives, often accompanied by expressions of the feeling of hopelessness and sometimes isolation from others:

The low spots were not being able to communicate, not being able to deal with feelings, not being able to um not being able to the madness in my head thinking that I was insane, no way to stop the feelings the projector going in my head, the suicidal thoughts, [not] wanting to live one minute and to die the next.

Well leading up to that I found myself very depressed, no one to talk to and I had all these memories and I was left alone.

Everything was just hopeless, it's really hard to describe, it was just a real feeling of desolation and hopelessness.

No. Because they were always helping me with what I sort of wanted to do but I guess I never really felt like I deserved it, deserved the help I was getting because I'd always be helped out with whatever dreams or interests I'd like to pursue. I guess that made it sometimes; sometimes I felt like I was spoiled at times as well so it wasn't that I didn't appreciate it I think mentally it was disturbing me because I didn't feel like I wanted it.

I still have wonders about what life's really about; probably think about whether life's really worth it still think about that once a day.

Sometimes the feeling can be one of anger:

I really don't know what the anger was about, I think it was just maybe because I was letting myself down a lot of the time - I let myself down a lot when I was younger. I didn't - because I was angry at myself and I didn't like myself very much I still don't like myself very much to a point anyway and I'm getting angry now because of my back now, back and neck has probably got me the angriest I've ever been in my life - it's a strange sort of feeling, it's a different angry than what I used to be when I was younger - I don't hit things now and I think that's probably making it worse too because I don't have an outlet these days to[get it out of your system] so I can feel my anger getting into me - it seems to be building up I guess because things aren't working out as much and...

Sometimes the feeling can be of frustration, of feeling in a maze or a "dream world":

I do want that to go well. I want my back to improve. I want my mind to improve. I want my motivation to have concentration levels and to be able to stick on something instead of wandering through on ideas.

I can still do that well enough. I probably have a bit more dream world than anything else. Dreaming about things that I might want to do, going places where I'd rather be.

At that time I had strange thought patterns, I couldn't work out what was going on inside my mind. I had delusions, voices, sadness, happiness, a range of different things and I just had no idea, I had no way of coping.

My uncle died and he died with mental health issues so she didn't want her son going down that track. He was a black sheep of the family and my mother insisted on me not going there to mental health people or drug and alcohol.

I allowed this to happen that I would literally frighten myself. I would build friendships and then I'd get paranoid and think these people are out to get me, they're going to get me, they're going to get me.

This sense of hopelessness, feeling that there is no way forward and little to hope for pervades many of the narratives.

2.1.4 Adverse childhood experiences

The comments of a significant number of participants and the narratives of those close to them point to the immense and predictable importance of early childhood. Research into the social determinants of health continues to highlight the enormous influence of the early years of life in terms of setting the patterns of balance and coping in later life[13].

There is some evidence that stress in childhood was strongly related to the development of risk factors in the health and social well-being of several of the participants.

One man remembered often witnessing extreme violence and aggression at home as a child. The household was dysfunctional due to his father's drinking. As he said:

My father was so obsessed with his drinking habits and what my mother was doing or wasn't doing and I look back now and it just seems so evident that everything was such a disaster to begin with.

I saw what I recall as very horrendous and graphic scenes of violence and sadness.

You know and I got home that night and my mother started crying and so dad told her to 'shut the fuck up' and gave her a bit of a flogging and then it was my turn.

Another spoke of his mother's new husband. He spoke of both his mother and step-father being alcoholics and physically abusing him:

So that progression, the emotional abuse, the emotional torture – my mum was very, very violent – on and on and I used to pray for her to drink because when she drank she was a black-out drinker and when she was off the booze she was extremely violent – dragging me around the house by the hair, punching me, slapping me, sending me off to school with polo neck shirts because my neck was scratched, she tried to choke me, she repeatedly slapped me, she emotionally put me down and told me I was worthless and told me I was like my real father who I never knew who he was.

This man became himself an abuser and links his childhood abuse to himself as an abuser:

I became an abuser, I became everything, I became a woman beater, I became a person beater, I became self-harming, drug addict, everything as a result of my childhood.

It is not only the domestic situation that has an impact but also those at school. Another man revealed the stressful events he experienced at primary school. He suffered from warts on his hands and was very self-conscious about this. One incident there caused him such humiliation that it left him with painful life-long memories. He described his teacher's behaviour:

...we used to have once a week dancing classes and he tried to force me to dance with a girl and I didn't want to hold hands with the girls because of my warts and he shouted at me and abused me in front of the class.

Once again, what might seem a trivial incident can be part of the build up of negative experiences in the pathways towards despair or suicide.

2.1.5 Relationship strain

Many of the participants spoke of strain in their important relationships. The research literature in this regard is clear about the importance of belonging, of being valued[14], connectedness between partners, between members of a family and between friends. In the narratives of the participants there are frequent references to problems in this area where relationships were disintegrating; attempters had a difficult time, exacerbated at least in one case by a sense of loss or separation from the children. They experienced a range of emotions, including a sense of loss, grief, pain, anger and a sense of failure. One man reported attempting suicide following his marriage break-up. His fear grew with the impending loss of his daughter because of the split. He voiced his fear in these words:

It was like – oh my God, I'm not going to see my daughter again, I'm not going to be able to see my daughter.

As we have said repeatedly, it is often the combination of the factors which seems to put the men at greatest risk: work also affected relationships. As mentioned previously, one attempter revealed that, as his business went from strength to strength, this involved him with an increasing number of business lunches and drinks, contributing to the break down of his marriage and his considerable stress.

Some participants spoke of strained relationships with members of their birth families. One had lost his biological father at a young age and his mother's addiction to alcohol made life extremely difficult, in addition to which he had difficulty in accepting his mother's new partner as a father. He described his feelings:

I was forced into going into a courtroom and sitting in front of a judge and saying that "do you want this guy to be your father?" and I didn't but I was petrified but I just done what I was told.

I had affairs. I had eight affairs but that was the one she knew about. I was confronted with the first time with the truth, she knew the truth and she told me that the marriage was over and she wanted me out and it all started all over again.

Yeah so that one had enough of me and she upstumped and left. Left me with the two kids.

The inter-relationship of the factors again appears here in several narratives: strain is compounded when mutual trust between the biological family and the survivor disappears. One participant broke up with his own parents and brother, causing tremendous stress as he sided with his partner's family in dealing with matters concerning his own family. He revealed:

My wife or my girl friend at that time basically turned me away from my family.

I'd basically cut off my family.

2.2 Accounts of families and friends who had lost a male family member or friend from suicide death

2.2.1 Drug and alcohol abuse

Like the survivors, several of the families and friends also described the impact of drug abuse on their suicide victims. They observed a strong link between drugs and relationship strains, addiction to drugs and poor mental health and low self-esteem in the victims of suicide.

Then with that, then maybe when he did split up and he wasn't getting any sleep and he wasn't eating right and he was smoking a lot of cigarettes and drinking a lot of beer.

...Yes. When he got off his medication, he got paranoid.

He was really paranoid look I can't do this and saying people are watching me and I'm getting scared now and I think that might have been the speed in his system at that time.

I think his attempt to be a husband and father was very real but we had the problem of alcoholism rearing its ugly head all the time and he didn't realise how much that affected his whole physical, mental, social, spiritual life.

It all started going wrong when he was about 17. He was just too tied up in sport and everything and was just doing so well. He should have played for Australia but he was getting on the wrong track with girls, he was getting involved with drugs and alcohol and the wheels all started to fall off then.

We do know that when he was living at home with us before he did leave, before he was 16 he was smoking a lot of dope...when he came down here, it seemed to feature a lot more strongly in his life... and that probably didn't help a lot of the other problems he was having but that was his escape and possibly his way of connecting with other kids....

I'm sorry I disagree with one thing: I think he had a drinking problem. He used to drink too much but that's from old eyes looking at young people. Like if I look back when I was twenty-one...

2.2.2 Work-related Issues

A number of families and friends narrated how adverse employment experiences, particularly a downward spiral of unemployment, lack of control over work, and exposure to long term underemployment were strongly connected with a growing sense of unease and frustration among victims. Other participants spoke of the positive (buffering) effect of good work-related experiences.

One participant, a sister of the victim, reported that her brother's self-esteem was severely affected when, in desperation, he took on a job which paid \$ 2.00 an hour. The sister said:

But his self-esteem just went out the window then that's why I think he had a big episode breakdown because like my self-esteem would go down too for \$2 an hour.

Unemployment in a society is a marker of a lack of social cohesion which in turn can be associated with suicide[15, 16]. Being isolated, not being part of a working community can increase feelings of vulnerability. One wife said of her husband who had committed suicide six years previously:

I think this unemployment was a big thing and he kept saying with all the knock-backs that he got that his age was against him.

He only had mediocre jobs that didn't earn the same money [as previously] and that was very frustrating to him and he got very depressed – he got quite depressed about that.

...and he always said his age was against him and he went for numerous jobs in (Capital city)...and he constantly got knocked back. And to see the look on his face was very soul destroying.

2.2.3 Relationship strain

Like for the group of attempters, this was revealed as a significant node in the interviews with families and friends. Many said that strained relationships severely affected self-esteem, as well as feelings of worthlessness and financial setback.

As has been said, there are often clear linkages between the factors, the cumulative effect mentioned already. In one instance, the partner finding work while the man did not led to what the partner perceived as strain, resentment in herself. As she expressed it:

... because I was still in the workforce and I had to be there so after 10 months of maternity leave I was forced to get back to work we just couldn't survive. So I could feel this resentment building up in me...

There are other references to difficulties in the relationship by families trying to make sense of the tragedy: one family member described the incompatibility in the relationship between the man and his partner:

I think they cared for each other very deeply but couldn't cope together...

I can see it now. I can. I still thought we were playing happy families right up until his death.

...and met a girl and eventually had his child but he was never allowed to see and that was aggressive and didn't help him.

2.2.4 Dissatisfaction with services

The main issues which emerged here were: 1. fragmentation of services, 2. need for more mentoring for inexperienced and newly qualified mental health workers, 3. perceived difference in approach between Drug and Alcohol Services and Mental Health Services: it was felt at least by some that Drug and Alcohol Services are more accustomed to males, while Mental Health Services had a more stereotypical view and did not get the "male point of view".

The narratives often refer to difficulties in times of stress when trying to get assistance from local services whether mental health, welfare or legal agencies.

Talking of these frustrations with the mental health services when trying to get help for her brother before his death, one sister said:

...something is really wrong with our mental health system. Like, there's lack of resources, nowhere to go...

In her perception there was inadequate consultation offered by the psychiatric staff, lack of co-ordination among service providers for treatment, loss of patient's records, all of this contributing to the stress of the victim when he needed the services urgently. Whatever services were offered often appeared to be a bandaid approach to helping a potential suicide victim.

...there's no records of his assessment to be released. So, in other words, he wasn't even assessed...

One family said the services offered by the mental health agency were not adequate. The psychiatric nurse assigned to their patient failed to fulfill her duty of care as she discharged him early from the hospital and did not take his suicide threat seriously.

Another family complained about the difficulty in getting one agency to release information which might help to trace a missing person who later committed suicide. When her husband went missing, she could not find out where he was:

When he went missing, I couldn't find out his whereabouts and he was drawing the dole up in Queensland and with the freedom of information, the police weren't allowed to find out from the Department of Social Security about these ...

She pointed out that if such information had been passed on between agencies, her husband might have been found sooner and received help to prevent his suicide.

In some cases, families encountered mental health workers who lacked experience in dealing with a potential suicide victim. They needed to have mentors from experienced workers who would provide much needed support and help to victims.

...you get different youth workers and you can tell who's a textbook worker and who's a real life worker...

The hospitals they just don't believe people. They don't take them all.... I feel they should take them all seriously. If somebody threatens suicide then take it seriously but they're not. It's ... once again... it's probably a money situation we haven't got hospital beds, we haven't got this, we haven't got that but it's ... and if the government thinks there's not enough, how many is enough. With one suicide, there's the mother, the father, the sisters the brothers, the aunts, the uncles, the best friends and they're all suffering for one suicide. One's too many.

I went to a counsellor you know poured my heart out to a counsellor it was very expensive and I needed something like..(inaudible) ... it was \$90, couldn't get it back off the health fund and this woman didn't know what it was like to lose a child. And I got my back up a little bit because she's saying get over it kind of thing or move forward. Not that harshly but do you know what I mean.

One family described their anguish when with dealing with the police who, in their opinion, were biased against their son who died from suicide. The police misunderstood him and discriminated against him as he was charged with assault.

It must be remembered, of course, that such research is giving a voice to the people involved, and this is important. The other side of the picture – listening to the frustrations of the service providers would reveal a long list of difficulties encountered by them, difficulties now being slowly acknowledged by society, under-resourcing of all kinds being the main one.

2.2.5 Resilience

We were interested in looking in the stories of both families and survivors for indications of what were the at least potential buffering or supportive factors, either in the persons themselves or in their

environments which gave them strength to hold on to life. While not attached exclusively to the word “resilience” we found that this notion was central to what we were looking for. We found that many researchers acknowledge the importance of social support for positive mental health or “thriving health”, for building resilience.

The notion of ‘resilience’ appears extensively in some related literature. Resilience has been defined as the capacity for successful adaptation to change, a measure of stress coping ability or emotional stamina, the character of hardiness and invulnerability, or the ability to thrive in the face of adversity or recover from negative events[17]. Resilience is thought to be an important protective factor against the development of psychiatric disorder in the face of adversity Rutter (1985) and Roy (2007) found it strange *that resilience had not been examined directly in relation to suicidal behaviour*[18, 19].

Some researchers have demonstrated that individuals who interact more with close, supportive, and comforting individuals on a daily basis show reduced neurocognitive and physiological stress reactivity to a social stressor. This reduction in stress responses, over time, may result in better health outcomes. Understanding the mechanisms whereby social relationships influence health unearths new possibilities for improving and maximizing health outcomes and reaffirms the importance of social relationships for survival[20].

We also discovered the literature on “hardiness”, something clearly related to resilience:

It helps to buffer exposure to extreme stress. Hardiness consists of three dimensions: being committed to finding meaningful purpose in life, the belief that one can influence one's surroundings and the outcome of events, and the belief that one can learn and grow from both positive and negative life experiences. Armed with this set of beliefs, hardy individuals have been found to appraise potentially stressful situations as less threatening, thus minimizing the experience of distress. Hardy individuals are also more confident and better able to use active coping and social support, thus helping them deal with the distress they do experience.[21]

Since in our study we are interested ultimately in suicide *prevention*, we were interested to look for suggestions of the presence or absence of resilience (and or “hardiness”) in the lives of those who had taken their own lives as reported by their near ones and in the lives of those who had attempted as reported by themselves.

From our “Node List”, we selected the nodes that could be related to resilience factors:

From the attemptees group, the following nodes were investigated:

- Social connections within family
- Social connections with religion

- Social connections outside family
- (Other) Resilience factors

Note: it was decided not to investigate the Effects on Family and Friends nodes as the contents of these nodes did not represent the resilient factors relevant to the person who committed suicide but the family and friends group members which is another important issue but beyond the focus of this study.

The following comments from attemptees tend, inevitably, to be a comment on the time after their attempt and point to what they see as being factors involved in helping them survive and turn away from suicide; often these protective factors concern some form of what we can call “social support”:

From his “new” (post attempt) perspective, one interviewee makes the general remark that “I can’t do this by myself” and lists those factors that he felt supported him to get through:

- Family (despite childhood trauma, positive comments on his parents’ efforts: “I wouldn’t be the man I am today if it wasn’t for a lot of their good attributes”
- Church and other social groupings:

I mean being part of, my being part of the church, being my faith in God, again in the 12 step program, being part of not being unique knowing that there’s other people out there like me and having that support network is very important whether it be AA, NA or GA.
Others mentioned the supportive element in the group dimension of AA

One interviewee spoke of the importance of connection with a supportive other person, in his case someone who had probably been in a similar position of despair:

I just had said it’s all too hard mate, I don’t want to be around any more and he picked up on that, ‘cause I think he’d been there himself. And he said “you’re in a very dark space” and came around and picked me up ...yeah...and I told him what I’d done.

It would seem also that where there is a lack of feeling understood, the lack of social support there is a negative effect on the person’s ability to cope:

People aren’t nice. I reckon one in every 10 people I reckon are genuine, maybe three or four of every ten are happy to be nice to you but I reckon there’s probably only one out of those one’s that are actually truly being happy when they say they’re happy these days or everyone says they’re good or they’re well or they’re fine but then as soon as something goes wrong and you say something to them, oh I’ve got problems, everyone’s got problems and everyone at work they’re never happy unless they’re whinging.

For some the love and support of a friend/partner is the lifeline: in one case which involved drugs and alcohol, the fact that the partner was drug and alcohol free was perceived as a positive factor.

For another, the unexpected visit in the hospital (after his attempt) by a friend from earlier in his life seemed to be the trigger from the beginning of hope in life: "I had a school friend come and visit me a few times and I thought people do care." He went on to form a positive relationship with this person.

Note that what has been said about negative beliefs about oneself being ingrained from childhood reinforces what the social determinants of health research tells us about the importance of early life for setting up people's physical and mental health and resilience for later life:

"Slow growth and a lack of emotional support during this period (early life) raise the life-time risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood" (WHO, The Solid Facts 2003). Not feeling valued can have a devastating impact on our capacity to deal with difficult times, our resilience. Speaking of his moving away from the feelings of despair which led him towards the attempted suicide, one interviewee said:

It's starting to get by where I'm starting to cope with these fears and these inadequates (sic) that I have in my mind, these beliefs that were ingrained at such young age that I was such a bad kid or such a bad person. It's only now come out that I can look at them and realise and say 'oh well, god doesn't make mistakes and god will be there for me at the end'

For one, lacking such a supportive person, he created one who became real for him whom he called Peter:

...I was actually crying out for Peter and at that stage Peter was a friend and Peter was all inside my head. I was calling out for this Peter and then searching high and low for this Peter and I knew all along that there was no Peter but I thought there was.

...this Peter talked to me when all else had failed.

Support from family: Several interviewees drew strength to go on with support from their birth families. One man had broken off contact with his family (because of differences his wife had with them); he and his wife split up and he was on the road to despair but his birth family came into the picture to support him:

And, um, my brother and I had been talking by this stage for about 3 or 4 months and we get along all right now and he and his wife turned up on the day of the court with their baby boy who absolutely adores me and they stayed with me the whole day eventually 8 or 9 hours.

Going on a holiday to visit my family who've been very supportive and my father and I have been getting on very well since we had our bust up.

3 DISCUSSION AND CONCLUSION

3.1 Discussion

From our data, it is apparent that for some men, the burden of a series of difficult life events and a sense of not feeling valued is a significant characteristic of the 'pathway' to suicide. This study supports the view that adverse life experiences such as neglect, abuse in childhood and an unsupportive early childhood environment can have a lasting deleterious effect on adult life. We have pointed out the cumulative effect of these factors and when they come together, they can weaken people's resilience. This can lead to an inclination towards drug addiction and abuse as coping mechanisms. Job-related issues would seem to have a particular significance for men. The narratives show that stress and problems at work often had a profound effect on the lives of suicide attempters as well as on those men who actually killed themselves. Interviews revealed that being employed in fulfilling work can often contribute to the resilience necessary to overcome difficulties in life.

The data show that loss and conflict associated with a relationship breakdown can lead some men to despair. Loss connected with children may be particularly traumatic and life threatening.

Again, there is no doubt that these individual risk factors in isolation rarely trigger the suicide attempts or deaths. They generally act in a cumulative way. Thus, individuals with higher exposure to several of the risk factors identified must be seen as being at a substantially higher risk of killing themselves.

We have also observed that those attempting suicides and the families/friends of suicide victims often had serious difficulty negotiating relevant services for help. Several felt that the mental health and legal services failed to give appropriate and timely help to men at risk of self-harm. Sometimes the services lack integration and effective referral systems to provide the full range of support for possible suicide victims.

3.2 Conclusion

It appears from these interviews with survivors and with families and friends who had lost a male relative or friend, that the pathways to suicide are often influenced by a complex set of life circumstances. Predictably, adverse experiences in childhood augur badly for adult life, if other factors then come in to play. Addiction to drugs, lack of support at home and at work, along with negative encounters with those services dealing with suicide all contribute to the problem among many men in our community.

The pathways to despair, which can lead to suicidal thinking and suicide attempts, can accumulate over a period of encountering adverse life situations (adverse childhood experience, school, addiction to drugs, relationship strain, work-environment, community life, separation etc). Perhaps most important is the *cumulative* effect of difficulties in several of these areas: when several of the factors are simultaneously involved, there is almost inevitably a greater degree of risk. A grasp of the broader context of acts of suicide and self-harm, the social determinants of suicide, is paramount for our understanding of these issues in order to draw up long-term strategies for promoting a public health approach to suicide prevention.

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