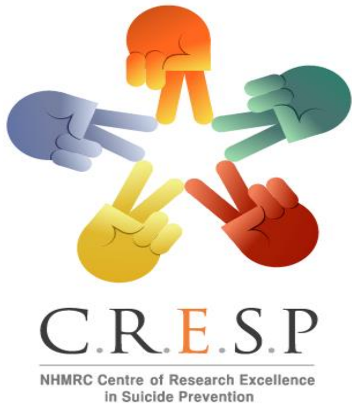

"MEN'S EXPERIENCES WITH SUICIDAL BEHAVIOUR AND DEPRESSION" PROJECT

FINAL REPORT

Proudly funded with donations from The Movember Foundation

This research undertaking is a *beyondblue* initiative

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MAIN MESSAGES

The development of suicidality in men involves well-known risks factors: (i) acute stress, (ii) depressed mood, (iii) unhelpful conceptions of masculinity (stoic beliefs and values), (iv) social isolation and other ineffective coping strategies. The elements tend to interact with each other and get worse over time, producing greater suicide risk and also creating barriers which interfere with attempts to treat depression or interrupt suicidality.

The pathway to suicide can also be predictable, providing opportunities for prevention and intervention. Several phases were identified in our project. In the first phase, a man may be affected by a series of stressors, often over a long time, and by using ineffective coping strategies, he becomes vulnerable to depression. The second phase is characterised by a sense of hopelessness and despair, where men described feeling powerless to stem the tide of negative life events, and began to plan ways to end the pain. Their thoughts turned to suicide often, which can normalise the idea, making it seem a viable option. Finally, in becoming acutely suicidal, men reported having tunnel vision and feeling numb, or cut off from the world. They may engage in risky behaviour, became 'irrational' when making decisions and reported feeling ambivalent about living.

Knowledge of the pathway to suicide, as well as a man's individual warning signs (e.g. anger, irritability, isolation, substance use or other uncharacteristic behaviours), provides an opportunity to interrupt the pathway and prevent suicide. Family and Friends can play an important role by being alert to changes in behaviour in their male friend/family member, which may indicate he may be thinking about taking his life. Asking him often if he is OK, telling him that they care about him, helping him to feel an important part of their world and discussing the consequences for them if he were to take his life are helpful strategies.

Men who had survived a suicide attempt reported needing to hear these messages from somebody close to them whom they trusted and respected, to prevent a downward spiral into suicidality. Activities and situations which provide the space and opportunity for a man to talk about personal problems among friends, free from usual responsibilities, are also helpful in preventing suicide. Male "bonding" activities such as fishing or camping were mentioned in particular. For acutely suicidal men, it is recommended that friends or family "do not leave his side" and seek professional help as soon as possible.

A number of clear messages arise from this project:

1. Public health campaigns and school programs are needed to increase mental health literacy in men, to help them tolerate and communicate emotions, and to recognise and act upon warning signs.

2. Messages should also emphasise that depression is common, and that when men have sought help for depression and suicidal thinking, their mood and wellbeing have improved.

3. Family and friends often want to help, but may be unable to recognise the signs of suicidality, know how to proceed or what to say. There may also be a tension between needing to take action for a man's benefit, which may be against his will. Interventions that address these gaps in knowledge and communication are needed.

EXECUTIVE SUMMARY

The purpose of the study was to identify contributors and warning signs for suicidality among men, and factors that may prevent or interrupt suicidal behaviour.

Data was collected in two phases, interviews and focus groups, followed by an online survey. Interviews were conducted with men who had recently attempted suicide, and focus groups were held with family or friends close to men who had recently attempted suicide. Participants were excluded if attempts had not occurred within the past six to eighteen months. Two online surveys were developed to examine male suicidality among broader samples of Australian men and family and friends. The majority of participants' reported feeling safe while sharing experiences during the study.

The study revealed both common risk factors and a common pathway leading up to suicidal behaviour. Awareness of common features and a pathway towards suicidality is important because it provides a valuable guide for: when and how to interrupt suicidal behaviour, and what warning signs may look like.

Recognising and challenging the core features of suicidality

Four core traits or experiences were common among men who became suicidal. These included:

- unhelpful core beliefs and personal values that overemphasise masculinity and stoicism,
- depressed or disrupted mood,
- presence of significant or personally meaningful stressors, and,
- a tendency to socially isolate and use avoidant ways of coping that tended to prolong or make problems worse.

These essential features interact and grow worse over time, increasing suicide risk, but also creating barriers that interfere with attempts to treat depression or interrupt suicidal behaviour.

Overall, the study suggests that interventions need to be initiated by people close to at-risk men, including the coordination of available community based support services, because men may not have the skills or motivation to cope or seek help independently.

An important finding of this study was the need for public education for at-risk males and their families, addressing effective coping and support strategies, and warning signs of risk.

The men in this study reported a limited capacity to tolerate or communicate distress, often leading to the use of unhelpful coping strategies. Men reported numbing their pain (e.g. through alcohol or drugs), or otherwise avoiding issues (e.g. by isolating themselves to avoid seeming weak or burdening others with their problems), rather than actively try to solve problems. This avoidance and isolation in turn made problems and depression worse, pushing men further along the pathway to suicidality.

People close to men at-risk reported that they often felt unsure about how to respond. Men tended not to ask for help, or were sometimes actively resistant to it. Therefore, families often felt unsure of how to approach, what to say, when to seek help from external services, what services were available, and if or when it was appropriate to intervene against the man's will.

Therefore, study findings suggested a need for education and intervention across the community focusing on:

- developing awareness about warning signs,
- better understanding characteristic behaviours related to aggression and risk taking,
- learning effective strategies for responding to stress or mood problems,
- developing a variety of resources and options for men with varied personal needs,
- challenging unhelpful cultural representations of masculinity, and
- breaking down common roadblocks to intervention.

Health professionals and allied services also play an important role in preventing male suicide. Men may come into contact with these types of services as a result of aggression, workplace tensions, stressful life events, drug or alcohol use, or mental health problems. Importantly, assessment and intervention in these settings should address not only suicidal thoughts and behaviours, but also the core contributors to suicidality.

While family, friends or services were often the initiators of interventions, study findings indicate that long term change can only occur through development of individual men's skills, self-perception and self-efficacy. For example, it is important that men learned to set small, achievable goals so that they experience regular small wins and develop 'positive momentum', confidence, and belief that things can change.

Interrupting the suicide pathway

Suicidality tended to develop over three distinct stages:

1. low mood and stressors interact to generate a downward spiral in mood and activity,
2. over time, suffering leads to hopelessness and suicidal thoughts, and usually a period of planning or preparation,
3. finally, men 'hit bottom', crossing a threshold of despair, at which time they may attempt suicide.

The current study showed that identifying where men were at on this pathway was very important, to guiding interventions that addressed the specific vulnerabilities and risky behaviours present at each stage. During stage one, men may be negatively impacted by internal or external stressors, leaving them vulnerable to depressed mood, which may be exacerbated by unhelpful self-perceptions and avoidant coping. Stage two is characterised by hopelessness and despair, with men feeling powerless to stem the tide of negative life events, and beginning to plan ways to end their pain. In Stage 3, men described having 'tunnel vision', feeling numb or cut off from the world. They engaged in risky behaviour, were ambivalent about living, and became 'irrational' when making decisions, often reporting that minor events acted as triggers for suicide attempts.

Accurately recognising and interpreting behavioural change is critical to interrupting suicidality in men – a task that men acknowledged having difficulty with. Men stated that they valued hearing repeatedly that people around them cared, and that successful intervention depended on being asked multiple times whether they were OK. These findings support the view that intervention should occur as early as possible to avoid increasingly unpredictable behaviour as men progress towards acute suicidality. Strategies for suicide intervention related to where men were on the pathway towards suicidality.

Preventing the downward spiral into suicidality may occur through:

- Male-to-male bonding, friendship, family or other group activities that provide opportunities to talk about personal problems, or feel connected to others,
- Physical activity and cognitive-behavioural strategies to address depression and improve emotion regulation,
- Providing men with positive but realistic feedback, normalising distress, and linking men to professional health services.

Interrupting plans or preparation for suicide involved:

- helping men to identify reasons to remain ambivalent, stay alive, or fear dying, rather than seek relief from pain through death,
- emphasising connectedness to family and other people, responsibility to others, and potential negative consequences of their actions,
- vigilant monitoring of behaviour and readiness to access external services to limit men's capacity to hurt themselves.

Men who survived suicide attempts described a cathartic learning experience, endorsing ways of coping inconsistent with previously unhelpful strategies. Alternate strategies included sharing feelings, and using cognitive and behavioural strategies to actively regulate emotions or deal with suicidal urges. Both samples described newfound skills, knowledge and bonds that reinforced interventions.

Roadblocks to suicide intervention

Participants outlined a number of important roadblocks for suicide intervention among males. These roadblocks were represented as five dichotomous conflicts operating within systems of support.

1. **Respect for privacy versus vigilant risk monitoring:** Men's moods need to be accurately assessed for effective suicide intervention. However males tended to resent the intrusiveness of family members 'checking in'. Check-ins therefore often triggered conflicts, damaged relationships or drove men to isolate further.
2. **Differentiating normal versus risky behavioural change:** Differentiating non-harmful behavioural change from change indicative of depressed mood and increased risk of suicidality was difficult. Assessment errors often resulted in relationship conflict or anxiety.
3. **Familiarity versus anonymity in risk monitoring:** Risk assessment and monitoring carried out by familiar versus independent individuals has various advantages and disadvantages. On one hand, familiar individuals were often better able to recognise and interpret idiosyncratic changes in behaviour. However, greater familiarity also potentially made listening without judgment or criticism more difficult, made certain topics taboo, or was at least perceived this way by at-risk men – thus making them less likely to disclose important information.
4. **Respecting autonomy versus imposing constraints:** Challenging unhelpful thoughts and restricting behaviour was often essential to keeping men alive, however, removing men's freedom to choose tended to put strain on relationships, trigger blame, distress, conflict and breakdown within family systems and social networks.
5. **Dependence on versus failures of external social service systems:** Many participants expressed frustration at health and social service systems. They identified various perceived failures related to: assessment of mood disorder and suicidality, scope or quality of intervention, and the extent of communication with family members. Some however,

reported that social services played a critical role in supporting individuals at-risk, due to a capacity to manage and contain risk more directly than families or friends were able.

Addressing each of these five conflicts will be critical to improving suicide interventions among men.

INTRODUCTION

This final report for the project covers the period from 15 July 2014 to 30 July 2014 and describes the Black Dog Institute's (BDI) activities relating to work on Milestone 4 of the project. It reports all activities related to completion of the project milestones, including quantitative and qualitative data analyses related to Phase 1: focus groups and interviews and Phase 2: online surveys.

OVERVIEW OF THE PROJECT

The project undertook a comprehensive exploration of men's views of their experiences with suicidal behaviour and depression, as well as the views of family, friends and others who have been impacted by men's depression and suicide. Contributing, protective and preventive factors regarding men's depression and suicidal behaviour were investigated.

Specifically, the project aimed to:

(a) Investigate Men's experiences of depression and suicidal behaviour (including thoughts, plans, and attempts) with a view to discovering the factors contributing to suicidal behaviour, interrupting suicidal behaviour, contributing to taking action, or not taking action, during a suicidal crisis.

(b) Explore the views of Family and Friends who have been impacted by depression and suicide to ascertain the factors contributing to suicidal behaviour, interrupting suicidal behaviour, and contributing to taking action, or not taking action, during a suicidal crisis.

(c) Explore the views of a sample of the broader Australian public who have had either lived experience of depression/ suicidal behaviour, or have been impacted by depression and suicidal behaviour by men they know, as to the factors that may prevent, manage or interrupt a suicidal crisis.

FINAL REPORT

Since the two previous reports on 30 June 2014 and 15 July 2014, the project team has:

- Finalised descriptive analysis of Phase 1 (interviews and focus groups) quantitative data and qualitative data
- Finalised data collection and descriptive analysis of Phase 2 (online surveys)

For the purposes of this report, we present the findings by Phase 1 and Phase 2 project activities. The two samples are reported as follows: "Men", indicating men who have survived a suicide attempt between six and 18 months ago, and "Family and Friends", indicating men and women who are family or friends of a man who survived a suicide attempt between six and 18 months ago.

Taken together the results sections meaningfully address the key research questions, by identifying the contributing factors to suicidal behaviour, including the identification of warning signs, and by clarifying the key factors that can prevent or interrupt suicide. The report also covers participant ideas on how to disseminate the information, discusses significant tensions that are evident in taking action to prevent or interrupt suicide, and concludes by considering the implications of the results for the project as a whole.

1. PHASE 1: FOCUS GROUPS AND INTERVIEWS

1.1 METHOD

Phase 1 data collection targeted two groups between March 2014 and June 2014:

- Men who had survived a suicide attempt between 6 and 18 months prior to recruitment
- Men and women who were friends or family members of men who had survived a suicide attempt between 6 and 18 months prior to recruitment

One-on-one interviews were conducted in person with men, and focus group discussions were conducted with Friends and Family members of men who had made a suicide attempt. Data were collected in in each state and territory of Australia in the following locations selected by beyondblue: Bunbury WA, Canberra ACT, Sydney NSW, Launceston TAS, Darwin NT, Cairns QLD, Adelaide SA, Melbourne VIC.

A thorough risk management process was in place throughout the project. All participants were monitored for signs of distress during participation and were identified as 'at-risk' if they reported: (i) a drop in mood after participating; (ii) high levels of current distress; (iii) experiencing suicidal thoughts in the previous two weeks; or (iv) distress during participation. Any participant who exhibited distress was followed-up by the facilitator on the day and a clinical psychologist was hired at each location to follow up 'at-risk' participants after data collection had finished. As reported previously, no further follow-up or referral to clinical services was required by any participant.

In addition, all participants received standard follow up in the week immediately after participation. This consisted of a telephone call to check whether participants had experienced any distress in the intervening time, see whether participants had any questions, acknowledge that participation can trigger unhappy memories, and to reiterate that Black Dog Institute can provide support, information and referral as necessary.

See Progress Reports 1 and 2 for further detail.

1.2 PROFILE OF PARTICIPANTS

Demographic details

During Phase 1, 35 Men participated in interviews, reporting a median age of 43 years (range 18 – 67). Just over one-third of the Men (34%) reported current employment, 46% were unable to work and 20% were unemployed, studying or retired. Just over half (54%) had never been married, 11% were currently married and 35% were separated or divorced.

Among the 47 Family and Friends who participated in the focus groups, 26 (55%) were female, the median age was 47 years (range 19 – 65) and a higher proportion reported current employment (53%), with only 19% unable to work and 27% being unemployed, studying or retired. In contrast to the Men, a higher proportion (49%) of Family and Friends were currently married or in a de-facto relationship, 28% had never been married and 23% were separated, divorced or widowed.

Table 1: Characteristics of Men (n=35) and Family and Friends (n=47)

Characteristics	Men (%)	Family and Friends (%)
Demographics		
Married/de-facto	11	49
Employed	34	53
Aboriginal/Torres Strait Islander status	6	13
Highest level of education		
Year 12	40	28
Trade or diploma	29	36
University degree or higher	26	34

Patient Health Questionnaire-9: Current risk of depression

All participants completed the Patient Health Questionnaire-9 (PHQ-9) before commencing their interview or focus group (Kroenke et al, 2001). The PHQ-9 is used clinically to indicate depression severity and inform treatment decisions. It has been shown to be sensitive to changes over time and responsiveness to treatment (Lowe et al, 2004). The PHQ-9 asks people how often in the past two weeks they have been bothered by a range of symptoms or problems. The total PHQ-9 score is then used to indicate whether a person shows minimal, mild, moderate, severe, or no depression.

For Family and Friends, the mean score on the PHQ-9 was 5.5, which is on the lower end of mild depression. The mean score for Men was 8.0, which falls on the higher end of mild depression. Figure 1 shows the proportion of both Men and Family and Friends in this sample who report mild, moderate, severe, or no depression in the two weeks prior to interview. The majority report either no current symptoms of depression, or only mild levels of depression.

Among the Men reporting at least mild depression (PHQ-9 score of 5 or higher) (n=24), 75% reported it was ‘somewhat difficult’ to do their work, take care of things at home and to get along with others, with 21% reporting it was ‘very or extremely difficult’. This was similar for Family and Friends with at least mild depression (n=20), where 65% reported it was ‘somewhat difficult’ and 15% reported it was ‘very or extremely difficult’ to do their work, take care of things at home and to get along with others.

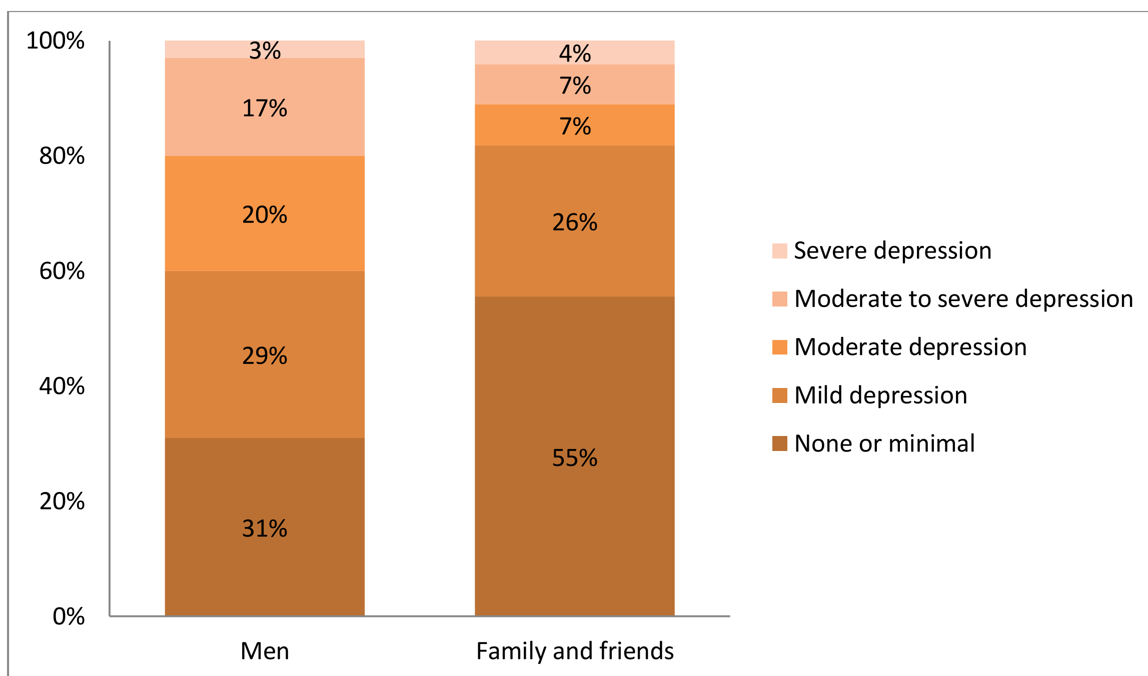


Figure 1: Depression severity for Men and Family and Friends, indicated by PHQ-9 score (N=82)

A majority of the Men (71%) and Family and Friends (87%) reported they had not experienced any suicidal thinking in the two weeks prior to participation.

Among the minority of participants who did report experiencing 'thoughts that they would be better off dead' 26% of the Men reported this happened on 'several days' and 3% reported this happened nearly every day, while 8.5% of Family and Friends reported this occurred on 'several days' and 4% reported this occurred on 'more than half of the days' or 'nearly every day'. All participants who reported experiencing suicidal thinking in the two weeks prior were identified as 'at-risk' of distress and were followed up according to the BDI risk procedures.

Male Depression Risk Scale: Current risk of depression

In men, avoidance, 'numbing', and externalising behaviours (e.g. aggression, risk-taking) can overshadow the typical DSM-V characteristics of depression like sadness (Cochran et al, 2003). Avoidance of distress through anger, substance use, or other suppression of feelings, can also be forms of coping for men. In recognition of this, the Male Depression Risk Scale (Rice et al, 2013) assesses multiple domains of 'externalising symptoms' associated with male experiences of depression. It is used as a measure of depression risk, not as a screening tool for affective disorders.

Consisting of 22 items, the scale provides scores for distress, drug use, alcohol use, anger & aggression, somatic symptoms and risk-taking.

Tables 2 shows the mean scores on each MDRS sub-scale for the sample of Men. Similar to the low levels of current depression indicated by the PHQ-9, mean scores on all sub-scales are low, with the exception of the distress subscale where the mean score was in the mid-range.

For this small sample of 34 Men in this study, there was a significant strong correlation between total scores on the PHQ-9 and the MDRS scales (r=0.83; p<.001), similar to other research (Rice et al, 2014).

Table 2: Men's scores on MDRS Distress subscales

	Distress	Drug use	Alcohol use	Anger & aggression	Somatic symptoms	Risk-taking
	Men (n=34)	Men (n=34)	Men (n=34)	Men (n=34)	Men (n=34)	Men (n=34)
Mean (SD)	12.3 (8.6)	1.6 (3.2)	4.6 (8.3)	4.9 (6.8)	3.7 (5.0)	2.9 (4.8)
Median	13.5	0	0	2	2	1
Minimum	0	0	0	0	0	0
Maximum	28	14	28	24	21	19
Possible range	0-28	0-21	0-28	0-28	0-28	21

Anxiety Disorder Scale-7: Current risk of anxiety

The GAD-7 (Spitzer et al, 2006) is a seven item self-administered scale used to assess the severity of generalised anxiety by asking how often people have experienced symptoms in the previous two weeks.

As shown in Figure 2, the majority of both samples reported no anxiety, or only mild anxiety. A higher proportion of Men (32%) reported moderate to severe anxiety compared with Family and Friends (11%).

Among the Men with at least mild anxiety (n=15), 60% reported that their symptoms made daily functioning 'somewhat difficult' and 33% reported it was 'very' or 'extremely difficult'. For Family and Friends with at least mild anxiety (n=15), 60% reported that experiencing these symptoms made it 'somewhat difficult' and 27% reported it was 'very or extremely difficult' to do their work, take care of things at home, or get along with other people.

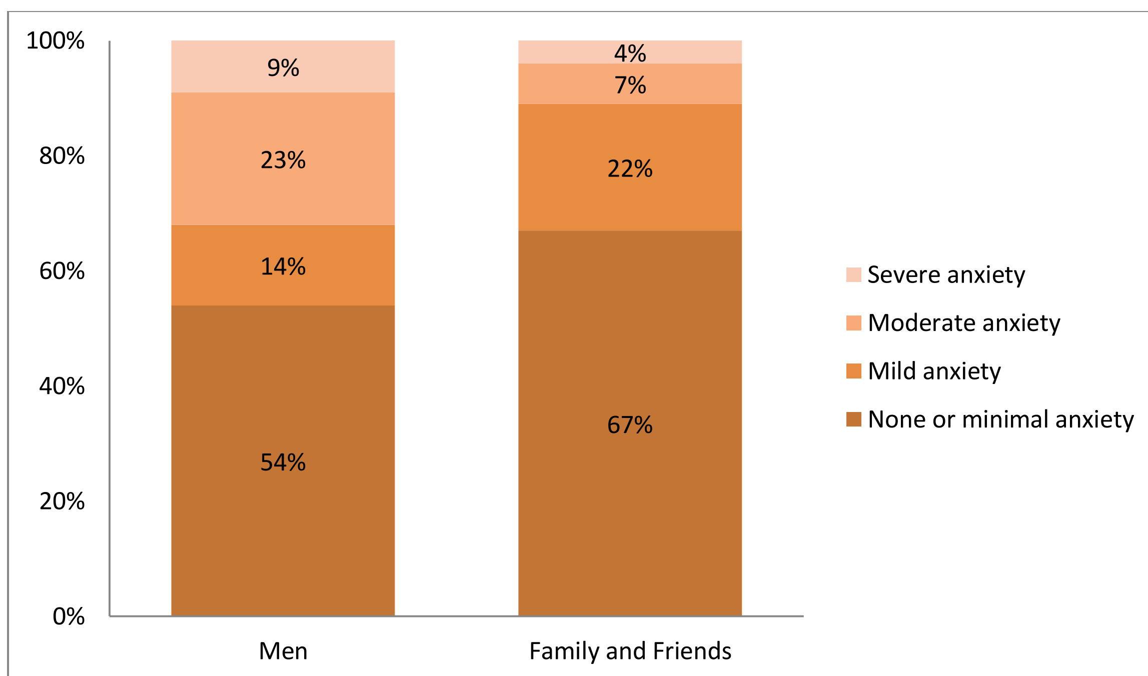


Figure 2: Anxiety severity for Men and Family and Friends as indicated by GAD-7 (N=82)

Key findings:

- The majority of Men reported low levels of depression and anxiety in the two weeks prior to interview.
- In the previous month, Men reported low scores on all MDRS sub-scales related to ‘externalising symptoms’ of depression, with the exception of the distress sub-scale.
- There was a strong correlation between the Men’s total scores on the PHQ-9 and total score on the MDRS.

1.3 RESULTS: FOCUS GROUPS AND INTERVIEWS

As previously reported, the majority (92%) of Family and Friends reported either a stable mood or an improved mood after participating in the interviews or focus groups, as indicated by their before and after mood-rating scores. This was true for Men also, where 94% reported stable or improved moods.

Core features of suicidality

As reported in Progress Report 2 (pages 8-10), both Men and Family and Friends agreed that there were four core traits or experiences common among suicidal men: (i) depressed mood (ii) unhelpful conceptions of masculinity (stoic core beliefs and values) (iii) social isolation and other ineffective

coping strategies, (iv) presence of stressors. These essential elements tend to interact with each other and get worse over time, producing greater individual risk of suicidality, and also creating barriers which interfere with attempts to treat depression or interrupt suicidality. In this report, we have outlined these core areas below with some exemplar quotes and further details where necessary.

Depressed mood

A lower mood may coincide with some or all of the following symptoms – decreased motivation and activity, poor concentration, tiredness, irritability and agitation, changes in sleep and appetite, and viewing things negatively. Development of a depressed mood often seemed to include an increase in anger (and related behaviours such as aggression and violence) in Men. Increases in these externalising behaviours are both a symptom and a sign of the exacerbation of depressed mood, which at times, served to keep friends and family away, and thus increased social isolation.

Unhelpful conceptions of masculinity

These conceptions related to 'stoic' core beliefs and values held by Men, and included the following:

1. Emotional 'toughness' which involved the suppression or avoidance of decisions influenced by emotions,
2. A sense of obligation to manage stress or negative emotions by themselves, rather than communicating these to others, and,
3. An unrealistic expectation of being able to cope with difficult situations, and about feeling happy.

As a consequence of these beliefs, Men reported that they had developed few skills in experiencing, tolerating and communicating emotions. Their emotional suppression and attempts to remain resilient were often exhausting, and contributed to their depressed mood. Failure to manage their emotions, or to live up to expectations of happiness and coping led to a sense of lost control, guilt, negative self-evaluations, and anxiety about having weaknesses or their failures revealed.

For example, one man related:

> *"With my closest friends it was, 'I don't want you to know how I feel'. I'm a dad of three kids and a husband. I've got a good job. I don't want you to know that I'm so sad that I cry at red lights."*

The negative impact on a depressed man's mood of unhelpful masculine beliefs was echoed by a Family and Friend participant who related:

> *"I'd have to say most men that I know are not happy to say 'I'm depressed', because society expects that men don't get depressed and men don't have feelings, and men don't get sad. If you get sad you're not a man. So even if they're feeling sad they quite often won't say it."*

These beliefs can be reinforced in the community and workplace. For example, one Family and Friend participant related the following about her husband's workplace:

"…you've got to go to the boozer on pay Thursday... And…they're your mates, but they don't want to know if you're falling to pieces. They don't want to know that. "Oh, you'll be right, mate," and even though 'they'll look after you,' they won't."

Social isolation and other ineffective coping strategies

Participants reported that unhelpful masculine beliefs often drove men to isolate themselves when they were feeling down, for example, to avoid imposing on others, or to avoid appearing weak. Through avoidance of others, Men reported that they didn't have to put on a false front, and that they felt comfort in the isolation. They reported that they didn't share how they were feeling because they found it disempowering, and isolation aided coping by allowing them to control what they expressed. Sharing of emotions runs contra to the stoic identity that gives them pride.

For example one man related:

"Pride. Such a small word but it means so much. Men feel like it's their problem and they don't want to share it. Well that's how I felt. That's why I didn't necessarily speak to counsellors, and stuff, because it's my problem, I'll deal with it, I'm a man. I have to get through it myself and no one can help me because I'm a man, I have to do it myself."

Men reported they were only likely to open up in limited situations (e.g. anonymous groups or with someone they trust), or at particular times (e.g. 'hitting rock bottom'). These conditions are likely to be idiosyncratic and changeable, in that each man described different, but specific conditions in which they felt comfortable disclosing feelings of depressed mood or suicidality:

"And I remember breaking down in the doctor's surgery. I was there just for an annual check-up and as soon as he closed the door I was a mess…I wouldn't allow myself to show it to friends and family. It was to a stranger where it was kind of like you felt that if you were going to be judged it would be far less than what it would be from family and friends."

This tendency of men to isolate, or use ineffective coping strategies, means that family and friends may remain unaware of suicide warning signs, or may mistake suicidality for depression or anger. Alternatively, in situations where they notice clear warning signs, they may be unable to effectively communicate with men displaying anger or substance use, or with men who are unable to communicate their feelings. Men and Family and Friends both reported this increased confusion or even interpersonal conflict, which in turn increased feelings of disconnection and loneliness in Men. It may also lower the motivation of family and friends to help, thus reinforcing social isolation.

The study highlighted the need for more opportunities for men to share with others. Men highlighted that there are very few groups for them to speak about life concerns unless they have crossed a threshold of significant distress, and are unable to cope alone. Groups that support a man's wellbeing include: Alcoholics Anonymous, Gamblers Anonymous, Narcotics Anonymous, and Dads in Distress. Men reported they attended these groups only in their greatest need, but did unburden themselves by sharing, as follows:

"It was someone that I could tell the story to and…it wouldn't be a friend at a social barbeque or it wouldn't be a family member at a birthday party… and the written rule about those is, you know what, it's anonymous and…you don't tell

other people's story. It's – so I told him mine knowing that no-one else would know. But I just needed to tell someone."

Stressors

Men and Family and Friends described a number of stressors that may cause, or interact with low mood and which may induce suicidality in men. Both samples reported that key stressors relating to personally meaningful life domains (e.g. employment or relationships) were likely to have a greater influence on a man's mood. Men and Family and Friends agreed that the following were key stressors: relationship problems and rejection, mental health problems, and problems arising from substance use. Men also identified several stressors of personal relevance: traumatic events, problems due to gambling, work or financial stress, involvement with the family court system, difficulties finding or keeping employment, boredom and lack of direction. Family and Friends listed a number of other key factors crucial to a man's mood: loss of control, lack of supports, involvement with the criminal justice system, and medication issues.

Any stressor, meaningful or not, had the potential to tip a man over the threshold from low mood to suicidality depending on the chronicity of his mood state. Men often reported that the particular stressor that triggered a suicide attempt was not necessarily of great personal significance by itself. Rather, the attempt was the result of a series of stressors, over an extended period of time, which culminated in the feeling of loss of control. Men therefore felt they were unable to change the momentum of negative life events, describing feelings of hopelessness and despair that the situation would change:

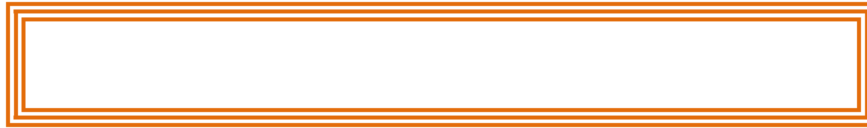
"It feels like you mustn't be normal because why can't I toughen up and realise, you know what, sometimes life's hard? But I couldn't toughen up. I was just exhausted. It's probably the only word. I was just like that's it, I can't do anymore…don't want to go on. It's hard."

And:

"… if someone could show me a way out, I'd be happy to take it. There's something that when it seems like you've gone down all the roads, you've tried all these things, like, and you can't find that way out, you know."

Key findings:

- Four core traits or experiences were common among suicidal men. These essential features can interact and get worse over time, increasing risk of suicide and creating barriers that interfere with attempts to treat depression or interrupt suicidal behaviour.
- Men reported that holding unhelpful masculine beliefs contributed to poor development of skills in experiencing, tolerating and communicating emotions.
- In turn, this added to the need to isolate themselves when they were feeling down – to avoid imposing on others, or to avoid appearing weak.



Phases of male suicidality

Results highlighted three distinct phases in the development of suicidality in men. Generally, men's suicidality began with a downward spiral into depression, continued through a planning phase, and ended with 'hitting bottom' and passing a threshold into acute suicidality.

The first phase refers to the way a man's mood may be negatively affected by internal or external stressors, making him vulnerable to a depressed mood through the use of ineffective coping strategies (as previously described). The second phase is characterised by a sense of hopelessness and despair, where Men described feeling powerless to stem the tide of negative life events, and began to plan ways to end the pain. Finally, in becoming acutely suicidal, Men described having tunnel vision and feeling numb, or cut off from the world. They explained they engaged in risky behaviour, were ambivalent about living, and became 'irrational' when making decisions, that is, they 'were not thinking straight at the time.'

Even where Men described situations in which they did not attempt suicide, they reported that their thoughts would turn to suicide habitually, while in a vulnerable state and that the constancy of these thought patterns normalised the idea of suicide in their minds. It may have allowed them to become more comfortable with suicide, and perceive it to be an option in the future.

Warning signs

Improved knowledge of the warning signs present during each stage of suicidality facilitates effective monitoring and appropriate responding. This takes on heightened importance in the light of Men's reports that they did not always acknowledge their low mood or intent to attempt suicide, or may only have acknowledged it only when acutely suicidal.

Family and Friends

Family and Friends reported the warning signs they generally witnessed were destructive, externalising, and numbing behaviours, such as aggression, risk taking and substance use. These signs have been extensively reported in previous studies (Brownhill et al 2005; Wilhelm 2009). However, in addition to these signs, Family and Friends reported noticing attempts by men to re-engage with their family. At times, men would covertly plan happy and joyful moments for the family to be left with. For example, one Family and Friend participant recalled:

> *"I think, just before everything, I noticed a bigger commitment to family, a bit of an effort made, which was never there before. It stood out as unusual."*

Similarly, another Family and Friend participant said:

> *"It was like a preparation for departure. He would always tell me how much he loved me and how important I am to him. And he even took the time to try and reconnect*

with his mother, which was unusual. And looking at those, I keep an eye out for those signs, in case."

Other warning signs Family and Friends reported included changes to a man's activity levels, losing interest in things they previously enjoyed, spending less time with friends, and in contrast to above, some reported men arguing more with loved ones.

However, Family and Friends also related their difficulty in identifying the warning signs or understanding the pattern of a man's emotions. At times they felt that the man in their lives had overcome their personal struggles, and presented as happy and resilient, which often left them shocked after the suicide attempt. For example, one Family and Friend participant related:

"And it seemed as if everything was okay and that my person had overcome it and moved forward with a smile on their face and was resilient. But…it seemed like a lot of little incidences that just kept compounding. And this person smiled all the way through it and so by the time they attempted, we had no awareness at all because they never let on. Yeah, so it was really shocking, yeah."

Men

Men also reported that externalising behaviours such as excessive displays of anger may have been a sign that they were not coping, and their suicide risk may have been increasing. For example, one man related the following insight into his anger:

"…you find yourself snapping at people quicker when you're run down and you're exhausted, and someone will cut you off and…you get angry and you want to jump out the car, and I suppose you take that same kind of pattern of thinking when you're down to that, you're thinking about taking your life, it's – in a sense it's not rational, it's not how you'd normally function."

Men also reported that pervasive negative thoughts could be a warning sign that they were becoming more depressed and the risk of suicidal behaviour was increasing. For example, one man related that when he is vulnerable to suicidal thoughts:

"It's all negative. The things I think of are all negative, or I see everything through a negative aspect, for sure".

Key findings:

- Suicidality tended to develop over three distinct stages:
    - low mood and stressors interact to generate a downward spiral in mood and activity;
    - suffering leads to hopelessness and suicidal thoughts over time, and often a period of planning or preparation; and,
    - men 'hit bottom', crossing a threshold of despair, at which time they may attempt suicide.
- Men may exhibit warning signs to Family and Friends,

which can provide clues as to phase of suicidality, and insights regarding the best way to intervene

- Family and Friends perceived some different warning signs of increased suicidal risk than described by Men
- Family and Friends reported difficulty in identifying or accurately assessing warning signs of increased suicidal risk

Key factors that interrupt or prevent a suicide attempt

Reports from Men and Family and Friends indicated there are salient time points where suicide can be interrupted in men.

Interrupting a man's spiralling low mood

Men discussed a range of personal experiences that helped improve their low mood and prevented the downward spiral to suicidality. These included male bonding activities, which provided the space and opportunity to talk among trusted friends about personal problems (e.g. camping or fishing), as well as 'spontaneous' physical activities or events that helped to break the circuit of negative thinking. Men also reported improvements in their mood from 'giving back,' through voluntary work, which provided a sense of mastery, contribution, and connectedness.

Family and Friends described a range of strategies to interrupt a spiralling mood that included: encouraging physical activity and organising activities designed to "get them out of their head" (e.g. go-karting), giving positive but realistic feedback, normalising the distress they were feeling, and even linking men to professional health services. Men and Family and Friends both emphasised that at the stage when a man's mood is worsening, family and friends must be persistent with their offers of support regardless of the number of rejections. Family and Friends also discussed the importance of creating a 'sanctuary' for men, where they can feel safe, comfortable about expressing emotions or asking for help, and can be in contact with family without effort (e.g. just watching TV with other family members).

Interrupting suicide attempts when a man is acutely suicidal

Men reported becoming overwhelmed and feeling hopeless after an extended period of suffering. They tended to make decisions to attempt suicide based on the extent to which their desire for relief from pain overcame the fear of death, or will to live. Direct intervention for acute suicidality involved limiting the man's capacity to kill himself. Examples of the latter included: involuntary admission to a mental health inpatient unit, or family members not leaving the side of an 'at-risk' man. One Family and Friend participant reported:

> *"What we did was we put our guy right at the centre of our universe and we made it very clear that he was the centre of our universe and nothing else mattered but him. He was not allowed out of our sight. And it was good because it stirred him up, it got him angry, it was, "Get away from me." "Good, if you're angry, you feel something, because a couple of days ago you didn't feel anything, there was nothing behind your eyes and that was bloody scary."…and then, with the anger, came the laughter.*

Somebody would do something and he'd crack up laughing and you'd go, "He's coming back." We can see it, he's feeling, it's the emotions, this is what we've been working towards."

Family and Friends further highlighted the importance of using connections with family, friends and the community to reinforce a man's reasons to live. This may be achieved, for example, by exploring the impact that his suicide would have on others, drawing attention to his connection, responsibility and obligation, to others. For example, one man stated:

"…it's a lot harder to make those plans to kill yourself when you know people are going to be hurt by it."

Men identified several additional factors which may successfully interrupt a suicide attempt. In response to the impulsiveness associated with acute suicidality, men should be encouraged and helped to slow their thinking, to systematically evaluate choices, and consider the implications of spontaneous behaviour. Family and Friends discussed the need to validate a man's feelings and to provide comfort. They also recommended doing something spontaneous and inconsistent with low mood, to take him out of his current mental space. Both groups emphasised the importance of persisting with men who may not respond to these actions immediately.

Protective factors that can prevent a suicide attempt

Men and Family and Friends also identified several key factors that may protect a man from making an attempt when he is acutely suicidal. These factors were often similar to those that interrupt an attempt in that they generally referred to the man's perceived responsibility to others, particularly family, and the actual fear of dying itself. For example, one man described how thinking about his son was enough to prevent him from making another attempt, without the need for others to intervene:

"My responsibility to him [new born son] is quite big, I think. I want to make sure that he's got good thought processes and I'm like, man, that's a big responsibility. So I'm like, well, I'm screwed now, aren't I? I can't even [think about suicide] because I've now got a responsibility to him."

Another man described that thinking about the pain of dying stopped him from making an attempt:

"One thing was, say, pain, like say if I had a gun. I thought about shooting myself and I thought, man, that's going to be painful. Or I thought about jumping off a bridge or something. It's just going to be painful. So sometimes when I thought of that sort of stuff I was too scared."

Men and Family and Friends both emphasised that the sense of responsibility to surviving family members was extremely potent in preventing a man from making an attempt, and that this sense of responsibility could be invoked when others needed to intervene to interrupt suicidal plans.

Specific strategies recommend by participants

Both Men and Family and Friends reported that successful intervention requires a particular type of interaction, at a particular time, which matched the level of the man's suicidality. It also requires regularly assessing, either informally or formally, how the man is feeling and the degree of risk

currently present. Participants outlined a number of strategies that may be used at different levels of risk. For example, Family and Friends found distraction useful:

> *"Distraction just works a treat, but with teenage boys it's easier to do something high adrenaline or totally blast everything out of their brain other than that moment of joy."*

Men reported that they sometimes found it helpful to have others impose themselves in their lives. They described that it helped to interrupt their pattern of isolation and made them feel connected to others:

> *"I think we've only known each other three or four years, where I just didn't want to get out of bed…He comes over in the morning, drops the kids off to school and comes over straight away, walks in the house and knocks on my door, opens the door, "Get up, make your coffee." And like it's – he's done that every morning of the week…just wouldn't let me sit in bed and sulk.*

Men found it useful to perform civic deeds. This allowed them to both distract them from their thoughts and enhance their feelings of self-worth:

> *"I also volunteer and that really helps. If I'm feeling insecure with myself I'll go out and help people and just feels like, man, I'm helping people and they're smiling, they're liking it. It's just like I'm supposed to be here; it's great."*

Other Men stated that seeking professional help made a difference to their level of risk and interrupted periods of acute suicidality when they had no other options obvious to them:

> *"So I thought I've got nothing to lose, I'll give this [psychologist] a go. There's some sense in what these guys are saying and they're not counsellors, they're not trying to tell me to smile and be happy. They're showing me the mechanisms of what's going on and I saw some sense in that, that we could change this..."*

Family and Friends expressed the desire for men to be educated in regulating their emotions. They consistently reported that men either didn't acknowledge, or didn't know how to deal with their low moods:

> *"I get the impression it's hard for my son to believe…that when he's in the middle of it, that anyone else can understand it or have lived it, or been there. So how can I help, or anyone else help, because he can't even figure it out for himself. He doesn't understand what it is or looks like.*

Family and friends also suggested that men should be helped to find their own solutions for their concerns. This builds self-esteem and provides confidence that they may be able to cope with further challenges in the future:

> *"And as soon as he realised he'd come up with the idea and it could happen, he tackled it in a different way and he's come out, at the end of the exams, two weeks ago, dare I say it, with a smile on his face… I knew what was possible, but I gave him some leading questions to let him then figure it out for himself, and that seems to have worked."*

Strategies that help men focus on what they have in their life can lift their mood. These were reported by Men to be successful at taking their mind off what is troubling them, as was spending time doing the things that routinely brought them pleasure. One man related his experience:

> *"…a good way of keeping [men] safe is trying to reengage with things that they like and love. It's hard to do that when you can't think of anything other than dying but it was about trying to think more about, 'these are some things that you know you enjoy."*

A very common response from Family and Friends was to help build a man's 'positive momentum'. They felt it was important to set small, achievable goals so that a man experienced regular small wins to help build confidence that they have some sense of control and that things in their life can change, and thus create forward momentum:

> *"Moving forward, is just continuous support and baby steps; 'little wins', as was said before… It's just making them see short term, and not the long term; how far away it is to the end of the road, but how you're going to get there, just step by step."*

Men also related that it was comforting to hear from other men that they were not the first person to go through this type or level of distress. This knowledge made the task of recovery a little easier knowing there was support or information available to help:

> *"Understanding that you are either not the only man having the issue or the only carer trying to deal with the issue, I think, is really a positive thing. 'Cause then, at least, you, kind of, feel like you can reach out to somewhere or get some ideas*."

Both Men and Family and Friends emphasised that, of course, all intervention strategies must make the man feel understood and that his feelings are valid, and maybe then he can be inspired:

> *"Listen to the man. One of things that I started to do was stop talking and start hearing. I'm a great talker and I can solve everything but I couldn't solve that. So I had to start listening and hearing what he was saying."*

And:

> *"Like I said, just create an environment where it's normal and quite acceptable for a man to show his emotions."*

Other intervention strategies suggested by Men and Family and Friends included ones already described in the literature such as exercise, healthy routines, physical affection, and using external supports such as community groups or acute mental health care teams.

Key findings:

- Family and Friends described the importance of persistence in the face of rejection while supporting a man at-risk of suicide.
- Knowledge of a man's suicidal pathway provides the opportunity to interrupt it by selecting an intervention

that matches both warning signs and phase of suicidality, as follows:

- preventing the downward spiral to suicidality included male bonding activities which provide the space and opportunity to talk about personal problems;
- interrupting suicide when a man is acutely suicidal included limiting a man's capacity or opportunity to kill himself, for example, by not leaving his side; and,
- protecting a man from suicide involved Family and Friends making the man feel an important part of their world. In additions, focusing on consequences for family was identified as a strong protective factor.

Roadblocks to suicide intervention

Men and Family and Friends identified a number of potential roadblocks to successful intervention with depressed and suicidal men. Participants tended to outline these roadblocks with reference to five apparent dialectics or dichotomies operating within the support system surrounding each man at-risk. Dialectics related to distinct, important elements or phases in intervention. Tension between the two elements of each dialectic tended to increase systemic stress - making intervention more difficult.

Dichotomy 1: Respect for privacy versus vigilant risk monitoring

The first dialectic involved attempts to balance respect for the man at-risk's privacy against the need to make potentially invasive or irritating mood 'check-ins.' Accurately monitoring mood and risky behaviour was identified by the majority of Family and Friends as a critical aspect of supporting and managing mood problems and suicidality. However, Men tended to perceive frequent inquiries about their mood as irritating, invasive, or patronising. These 'check-ins' were therefore likely to trigger conflict, damage relationships within families or friendships, or drive men to become more reclusive. For example, one focus group member observed:

> *"…they tend to say that they would be better if you weren't pestering them by trying to get in contact with their feelings or their emotions…"*

On the other hand, regularly talking to men about their mood was considered an important means of monitoring risk, particularly among men known to have low motivation to communicate about how they feel. Checking in was also an important means of breaking down a tendency to isolate as individuals became more depressed or chronically irritable. One Family and Friend member observed of a suicidal man:

> *"…basically, when it all got too much, he'd just go bush. He'd just go out in the bush, take his tent and isolate himself."*

Therefore, allowing a man to totally isolate himself risked missing important warning signs, and further exacerbation of a depressed mood. Several negative outcomes resulted from the tension set up within this dialectic. Tension was likely to increase anxiety in the system due to perceived loss of control by the man or carers, and damage to rapport between individuals. Even when Men were relatively open about their suicidal ideation or plans, awareness of ongoing risk to a family member tended to increase stress and anxiety within the system.

> *"…when it comes to friends and family, it's the fear that I'm going to do more damage because I'm too close to it. And, I guess, allowing someone to express themselves, knowing that, a lot of that anger could possibly be directed at me."*

Men and Family and Friends suggested a number of potential solutions to address this dialectic. Regular monitoring was argued by a majority of participants as unavoidable and essential, and therefore something that must occur regardless of the additional stress it may generate. Negative impact may be ameliorated however by providing at-risk men with information about support services outside the family, or by sharing information with other people in contact with the individual.

Dichotomy 2: Differentiating normal versus risky behavioural change

Men and Family and Friends indicated that monitoring risk typically involved watching for signs of change in behaviour. A second dialectic therefore related to differentiating non-harmful behavioural change from change indicative of depressed mood and increased risk of suicidality. For example one Family and Friend participant noted of their son:

> *"The other thing that I found difficult was to work out what was normal teenage behaviour and what was actually locking himself away because of being down… I found it hard to work out the balance... 'is that suicidal behaviour, or him being a teenager?'"*

Family and Friends noted this dialectic was particularly relevant among adolescents, since many of the typical activities of this group were similar to indicators of depression and suicidality. For example, during teen years adolescents often engaged in riskier behaviour, were more irritable and emotionally reactive, and sought greater autonomy and privacy. However, even among adult men, behaviour change may be due to reasons other than descent into suicidality, such as unrelated breakdowns in relationships. Similarly, statements of suicidal ideation or intent may occur for reasons other than genuine intent.

Again, Family and Friends reported that the difficulties of accurately evaluating behavioural change triggered anxiety and guilt within the support system - due to a sense of lost control and confusion about responsibility. Uncertain risk assessment often led to either false positives, contributing to conflict between men and carers, or false negatives resulting in insufficient support, or self-harm. Family and Friends highlighted the importance of third party consultation about mood and suicidality as a means of decreasing risk associated with this dialectic - citing various professional services skilled in assessing suicidality and mood problems, such as general practitioners and psychologists.

Dichotomy 3: Familiarity versus anonymity in risk monitoring

A third important dialectic related to independent, professional consultation for at-risk men. This dialectic related to the advantages of risk assessment and monitoring carried out by familiar versus

independent individuals. On the one hand, familiar individuals were often better able to recognise and interpret idiosyncratic changes in behaviour. As one Family and Friend participant observed:

> *"I was aware that that wasn't his standard way of life … it became an obvious sign. I do understand that it was only… because I actually knew the person for a longer period of time."*

However, greater familiarity also potentially made listening without judgment or criticism more difficult, made certain topics taboo, or was at least perceived this way by at-risk Men - making them less likely to disclose important information.

An 'independent arbiter' may therefore provide a different point of view, act as a 'circuit breaker,' or may bring clarity of perspective based on professional detachment. Anonymity and perceived freedom from judgment potentially made it easier for Men to open up about problems and feelings. However, at the same time, outside observers may be less likely to identify idiosyncratic behavioural cues, signs of deception, or behavioural change. One Family and Friend participant commented:

> *"I completely agree about finding someone else, something else, whatever it is to help them, because in the situation that they're in, they're emotionally, physically, whatever it is, in a very bad state. And the people that are around them, that they're used to, they're aware of it, but the person is also aware of them… they're seeking something outside of what they know… half the reason this stuff works is because they actually don't know the face on the phone, and they know that that person isn't going to judge them any differently…"*

Family and Friends reported that again this dialectic may result in increased stress and perceived loss of control, as well as ineffective risk monitoring and management. Simply choosing the wrong time to approach men, for example, may damage rapport or lead to inaccurate risk assessment. One solution suggested by participants was to ensure that men are aware and linked in to both familiar and external support systems during times of distress.

Dichotomy 4: Respecting autonomy versus imposing constraints

Managing risky behaviour was identified by most Family and Friends as a further critical aspect of supporting at-risk men - distinct from risk monitoring. The extent to which a man's autonomy was respected or constrained during this process represented a fourth important dialectic. On one hand, challenging unhelpful thoughts, and restricting behaviour was often essential to keeping people alive and safe, such as when intent to self-harm was active and strong. However, removing men's freedom to choose tended to put strain on relationships, trigger blame, distress, conflict and breakdown within social networks and family systems.

Family and Friends reported that men were often difficult to reach, describing various instances in which men expressed reluctance to engage with support, or refused to accept the type of care being offered. For example, one group member reported:

> *"I know from my own personal experience, with my dad, he won't accept the help really. I could set up a hundred different things, to be honest, but he'll say, 'no, I don't need it'… So it's a struggle when they put the wall up…"*

In addition, managing risk sometimes required individuals or services to impose limits on men's choices in order to prevent harm, for example, restricting movement or access to potentially harmful

implements during involuntary placement in inpatient health services. One Family and Friend participant described observing police intervene with a suicidal cohabitant:

> *"…there were police in the driveway. 'Does such and such live here?' 'Yes he does.' And, "Look, can you come down? He's lying in the middle of [street name]'… and by the time I got down there they've already got him off the side of the road – off the road and onto the side of the road. And got him in the police car and took him home. And he's actually took a few swipes at the copper. A good guy, he just let go, and like it's – trying to help him, trying to help him was really hard."*

Tension generated by this dialectic tended to result in anxiety, stress, and anger among men and their support systems - sometimes with reciprocal influence. One Family and Friend participant reported that restricting a man's capacity to hurt themselves through an unwelcome admission to hospital, helped alleviate anxiety among other members of the family.

Several previously suicidal men argued that decision making by acutely suicidal men was often affected by impulsiveness, did not follow systematic reasoning, or lacked insight into other available options that may develop via treatment or contact with support groups. As such, an overall majority of Men and Family and Friends agreed that managing risk of suicide sometimes required acting against the immediate wishes of at-risk men, meaning some dialectical tension may be an unavoidable aspect of effectively managing male suicidality. Several participants argued that support should nevertheless attempt to increase perceived self-efficacy, such as by minimising unnecessary restrictions.

Dichotomy 5: Dependence on versus failures of external social service systems

A final dialectic concerned the role of external services in monitoring and managing risk. The majority of participants reported problems with welfare or health services supporting men at-risk. Men and Family and Friends also identified that services often held additional resources, or had capacity to manage risk in ways not available within normal family and social networks.

Family and Friend participants often expressed frustration and criticism at health and social services systems. They identified various perceived failures related to: assessment of mood disorder and suicidality, scope or quality of intervention, and the extent of communication with family members. Participants reported that these failures tended to damage relationships, and faith in interventions, making ongoing support more difficult. For example one Family and Friend participant reported:

> *"He was injecting speed, drinking from eight o'clock in the morning, drinking all day and every day, being aggressive with everybody. Nobody could talk to him. I took him to the doctor and they sent him to mental health, who put him in hospital to try and dry him out, which was a disaster. They ended up calling the police and they threw him down the hallway and handcuffed him and … yeah, he didn't get the help, the right sort of help…And, yeah, that made him a lot worse and then he just decided that he didn't want help anymore, that he 'would be fine, everybody just leave him alone'."*

On the other hand, participants reported that social services played a sometimes critical role in supporting individuals at-risk, due to a capacity to manage and contain risk more directly than could family or friends, often indirectly helping families to deal with the stress and anxiety. One man in the study reported:

“I suppose I used more of what was actually out there than a lot of people did. A lot of people don’t know what services are out there for those sort of things… psychologists, psychiatrists, counsellors, they’re great, especially in a mental health plan.”

At times, simply changing the environment around a man using external services acted as a useful ‘circuit breaker’, for example by generating a community around otherwise isolated men.

Participants observed that frustration, confusion and distrust directed at the service systems tended to reduce the effectiveness and cooperation between internal and external care providers, and thereby the quality and consistency of support for men at-risk. Several Family and Friends suggested that providing skills, training and psycho-education to families and friends early on would improve support to men at-risk, as well as understanding of how service systems operate, reducing reliance and resentment towards relevant services.

Key findings:
Five key dichotomous conflicts arose that act as roadblocks for suicide intervention among males:

1. Respect for privacy versus vigilant risk monitoring – the balance between essential ‘check ins’ on men’s moods by Family and Friends, and the conflicts these may create can drive men to isolate further.
2. Differentiating normal versus risky behavioural change –correctly differentiating non-harmful behavioural change from that indicative of increased risk of suicidality can be difficult.
3. Familiarity versus anonymity in risk monitoring - Individuals who are familiar to the man are often better able to recognise and interpret idiosyncratic changes in behaviour. However, greater familiarity also potentially makes listening without judgment or criticism more difficult.
4. Respecting autonomy versus imposing constraints - challenging and restricting risky behaviour was often essential to keep men alive, however, removing men’s freedom added conflict within social and family systems.
5. Dependence on versus failures of external social service systems – many participants expressed frustration at perceived failures in assessment and treatment of suicidal men, but others acknowledged a greater capacity to manage and contain risk more directly than they could.

Stories of recovery in the experience of suicidality

As a conclusion to this section on the results from the interviews and focus groups, we report on the stories of recovery that were also described by participants. Nearly all Men and Family and Friends offered a story of a man’s recovery, featuring personal growth, acquisition of new coping skills and/or improved social and family ties after the suicide attempt.

Improved bonds

In general, the relationships described by both Men and Family and Friends were considered to be closer and better functioning after the suicide attempt. Families felt their relationships had been strengthened, and that there was a new closeness and connection between them. They reported that the attempt caused reflection, and reinforced how much family loved and cared for each other. For example, one Family and Friend participant reported:

> *"Nothing is off the table now, everything is open…"*

One man described the suicide experience as both positive and part of an ongoing journey:

> *"…formed a more – a different sort of relationship, better, not worse, but certainly better than what was there previously. So that's the positive or the good outcome of it and I think, like I said, the journey hasn't stopped, it's still going, but you're sharing and interacting on a different level to what may have been…."*

A father described that the improved relationship he enjoyed after his son's suicide attempt was a source of pride:

> *"I think the thing I'm proudest of is that every time I catch up with my young bloke, we give each other a hug and that's – I mean, he's achieved some really good things but just a hug every time is really good."*

Growth and gratitude

Subsequent to their suicide attempt, Men reflected that they were now able to better regulate their emotions, by using a number of different techniques including mood-monitoring, challenging negative thinking, keeping active and in contact with other people, selecting activities that promote a sense of purpose and contribution, actively noticing achievements and positive events in their life, and using these to increase positive thinking.

In addition, Men and Family and Friends described increased strength and resilience after coming through the distress of the suicide attempt. For example, one Family and Friend participant expressed the following:

> *"I just feel, yeah, so grateful that our family member is still here and I feel, personally, I've just grown so much more in resilience because of it as well, and you just know that no matter what you face, that - that, yeah, you'll just always love them and be there and do whatever you can."*

This was echoed by a man who related that though the memory is painful, recovering from his attempt helped him to learn new skills and have pride in his development:

> *"I've got a lot of guilt and shame and remorse, but I have my kids five nights a fortnight and I'm a good dad. I was forced to ask for help and I'm so super glad that I did. Nothing gets taken for granted anymore. I'm proud of myself that I can emotionally live on my own…I don't have patience, but I've got a lot more patience than what I had last week or 12 months ago. So I'm proud of a lot of little things that have got me here today, like here in this building."*

Key findings:

- Ideally, Men should be assisted to find their own solutions for their problems. This allows Men to build self-esteem and also confidence that they can cope with future challenges.
- Post-suicide attempt men reflected that they were now able to better regulate their emotions. They described greater self-awareness and confidence in managing periods of risk, and closer bonds with family and friends, which reinforces support for the recommended interventions

2. PHASE 2: ONLINE SURVEYS

2.1 METHOD

Building on the key findings from Phase 1, two online surveys were developed to explore issues about men's suicidality from wider geographical base across Australia. Similar to Phase 1, the surveys were targeted to the following groups:

- Men who had survived a suicide attempt between 6 and 18 months prior to recruitment
- Men and women who were friends or family members of men who had survived a suicide attempt between 6 and 18 months prior to recruitment

Details of the development of the surveys were outlined in Progress Report 2. The intended sample size for the two surveys combined was 100 participants. However, we are pleased to report that, due to an intensive promotion and publicity effort, we were able to recruit nearly 300 people (176 Men who had made a suicide attempt in the previous 6-18months and 118 Family and Friends of men who had made a suicide attempt in the previous 6-18months).

Participant mood before and after the survey

In order to monitor participant mood, survey respondents were asked to rate the strength of four emotions before they commenced the survey and again at its completion. Table 3 shows the mean score for each emotion rating for both samples. All scores were either stable or improved after the surveys.

Table 3: Pre and post survey ratings of emotions (Men and Family and Friends of men)

Emotion	Men		Family and Friends	
	Pre-survey score	Post-survey score	Pre-survey score	Post-survey score
Sad	6.6	6.6	4.3	4.0
Irritable	5.6	5.3	3.2	2.7
Agitated	5.6	5.3	3.3	2.9
Anxious	6.5	5.9	4.3	3.5

2.2 RESULTS: ONLINE SURVEYS

2.2.1 Results of Men's Experiences Survey

Demographic profile of respondents

In total, 176 men who had made a suicidal attempt in the previous 6-18 months completed the Men's Experiences survey. Their median age was 36 (range 18-73). One quarter were either unable to work or unemployed, just over half were employed and 41% were married or in a de facto relationship (Table 4). Just over two-thirds reported that their health was good, very good, or excellent, leaving one-third whose health was only fair or poor.

Table 4: Characteristics of Men (n=176)

Characteristics	Percentage
Demographics	
Married/de-facto	41
Employed	58
Aboriginal/Torres Strait Islander status	1
Highest level of education	
Year 12	27
Trade or diploma	47
University degree or higher	27

Language used to describe feeling depressed or suicidal

Men were asked what words they used to describe being really down or feeling that life wasn't worth living, and were presented with a list of possible options generated from Phase 1 data. Men could choose as many items from the list that applied to them.

Table 5: Words men use to describe feeling depressed or suicidal (n=176)

Words	I use this to describe when I'm feeling suicidal %	I use this to describe when I'm feeling depressed %
Useless or worthless	69	30
I've had enough	65	30
Hopeless	63	23
Pointless	60	23
Over it	57	34
Lost	54	34
Fed up	46	34
Tired	39	49
Not going too well	29	48
Deeply sad	29	27
Stressed	27	51
Angry	19	39
Down in the dumps	9	44

Men use different words to describe feeling depressed vs feeling suicidal (Table 5). The words most commonly identified to describe feeling depressed were *stressed, tired, not going too well, and down in the dumps*. The words most commonly used to describe feeling suicidal were: *useless or worthless, I've had enough, hopeless, and pointless*.

Warning signs of feeling depressed or suicidal

The behaviours that men commonly said others might have noticed when they were feeling down or suicidal primarily centred on withdrawal: shutting themselves away, loss of interest in everything,

changes in sleep and poor self-care (Table 6). The next category of behaviours endorsed by men focused on emotional disturbances: being flustered or easily upset, and irritable. Few Men reported that they had actually told people how they were feeling or said goodbye to those close to them.

Table 6: Warning signs that men are feeling depressed or suicidal

Signs	n	Strongly agree %	Agree %	Neither agree nor disagree %	Disagree %	Strongly disagree %
I was sleeping more or less than usual	157	63	24	10	2	2
I shut myself away	153	62	26	8	4	1
I lost interest in pretty much everything	157	58	29	8	3	1
I was not eating well or taking care of myself	156	57	26	9	6	1
I was flustered, easily upset	153	44	39	15	1	1
I was irritable, particularly with my family	148	39	38	18	4	1
I was on autopilot, doing things without thinking about it	153	33	36	26	3	2
I was drinking more alcohol	154	33	12	16	19	20
I was more aggressive towards others	151	21	35	21	17	5
I was taking more risks, e.g. driving faster	155	20	27	27	17	10
I was using more drugs	149	16	11	14	22	38
I said goodbye to the important people in my life	156	15	29	21	21	23
I told people how I was feeling	157	14	29	14	22	21

Barriers to help-seeking

Men were asked to nominate what got in the way of their seeking help. The most frequently nominated barrier to seeking help was that they had distanced themselves from everyone. Other reasons were: not wanting to be a burden to others, a tendency to bottle up feelings and a sense that everything seemed pointless. A much smaller proportion of Men (12%) said that they didn't know where to get help. Only seven per cent of Men said that they were able to get help (Table 7).

Table 7: What got in the way of men seeking help

Barrier	n	Percentage
I had distanced myself from everyone	96	55
I didn't want to burden others	95	54
I tend to bottle up my feelings and it's hard for me to talk about it	84	48
I just couldn't see the point in getting any help. Everything seemed pointless.	81	46
It was my responsibility to handle it	62	35
Suicide was my go to plan and I wasn't going to let go of that	62	35
I was worried that if I told someone I would be hospitalised	62	35
I had no one around me that I could talk to	59	34
The service (e.g. doctor, psychologist, counsellor) I tried wasn't helpful	49	28
Society's view of men - this expectation that men are tough and should be able to deal with their own issues.	47	27
At the time I couldn't see how bad things really were	45	26
I wanted someone to help but I wouldn't ask for it	41	23
Other	40	23
I didn't want to accept help – that's not me	31	18
I didn't know where to go for help	21	12
Nothing – I was able to seek help	13	7

Other barriers to help-seeking were identified in respondents' free text answers. These included: believing that they had no support to get help from family, being isolated and having a sense that no one cared. There were also service barriers, such as cost and having had a negative experience previously with medical or mental health professionals. Some, having found that treatment hadn't worked in the past, believed that nothing could help. Several men spoke of a sense of shame about telling others what they were thinking and feeling, whilst others expressed a fear of negative consequences (employment, relationship) if they revealed their suicidality. Some men found it hard to admit there was a problem, or thought they could beat it on their own. Others said that they were simply too exhausted and unable to see through the fog to get help. Finally, some men expressed a sense of being a burden, or that life would be easier for others if they died.

Key findings:

- Self-reported warning signs that a man is feeling down or suicidal included:
  - isolation and losing interest 'in everything';
  - changed sleep patterns; and,
  - reduction in self-care.
- The most commonly reported barriers to Men 's help-seeking during a suicidal crisis included:
  - Withdrawal and isolation
  - Unwillingness to burden others
  - Unwillingness or inability to talk about problems

Interrupting and preventing suicide

When asked what stopped them from attempting suicide, the majority of men endorsed the item 'thinking about the consequences for family' (64% agreed or strongly agreed). This theme of concern for others was apparent in other strongly endorsed factors: just over half (53%) agreed or strongly agreed that not wanting to put the burden on someone finding them was a barrier to suicide, followed by 46% endorsing not wanting people to feel it was their fault. Although fewer men strongly agreed, a substantial proportion agreed that being afraid to die was a barrier. More than one third said that having a friend or family member express their concern and then follow up with support stopped them from attempting suicide. When asked to nominate the most important factor, consequences for family was also most frequently nominated (32%), followed by not wanting to put the burden on someone finding them (8%).

Table 8: What stopped you from attempting suicide? (n=150)

Barrier	Strongly agree %	Agree %	Neither agree nor disagree %	Disagree %	Strongly disagree %
I thought about the consequences for my family	37	27	12	12	12
I didn't want to put the burden on someone finding me	24	29	17	15	15
I didn't want people to feel like it was their fault	19	25	21	19	17
My kids wouldn't know me if I died now	17	14	27	14	27
I need to be here for others	16	21	23	19	21
A friend or family member who was concerned and followed up with real support	15	23	15	19	27
I really don't want to die	12	14	26	23	25
Someone gave me hope	11	18	21	24	27
I broke the downward spiral by asking for help	11	19	27	21	23
I was afraid of dying	9	27	26	14	24
Good friends spent a lot of time with me	3	15	19	29	34
I believe it's wrong	6	7	27	24	37
Know that I was valued	6	15	26	23	31
I had a specific commitment to help someone	4	7	31	23	35

Men were also asked to rate the importance of a number of factors that may be helpful for interrupting a suicide attempt. Almost 90% of Men said that support from someone they really trust and respect was important (Table 9). The kind of support was also important, with Men saying they did not want to be told that everything will be okay – rather, they wanted someone to listen with an

open mind, and to know that the person can hear the truth without judging them. Around three quarters of Men said it was important to hear that others are going through a similar situation and that it is normal to struggle sometimes. More than two-thirds wanted others to notice the changes that they were experiencing (e.g. withdrawal, irritability).

Table 9: What interrupts a suicide attempt?

Factors that interrupt a suicide attempt	1 Extremely important %	2 %	3 %	4 %	5 Not at all important %
Support from someone I really trust and respect	64	22	8	3	3
Don't tell me that everything will be ok, listen with an open mind	57	25	12	3	4
I need to know that others can hear the truth and they won't judge me	56	19	12	4	8
Let men know that others are going through this too, it's normal to struggle sometimes, there is help	45	29	16	5	6
Someone needs to notice the changes in me	33	35	17	7	9
You need to be very direct with me, tell me you know what's going on	32	28	22	11	7
Help me to break my problems down into smaller pieces and set some goals	28	29	25	7	11
Encourage me to do more things for myself	27	22	23	14	14
Friends or family have to get in my face and stay there	24	22	23	14	17
Get me involved in something bigger than myself	23	28	21	15	13
Talking to a friend	18	25	32	11	14

Key findings:

For men, the most commonly reported factors that prevented suicide included:

- thinking about the consequences for family;
- unwillingness to burden others; and,
- not wanting family or friends to feel it was 'their fault'

The most commonly reported factors that interrupted an attempt included:

- support from somebody trusted,
- being listened to without judgement by somebody with an open mind; and,

- hearing that other men have experienced the same thing.

Current risk and previous history of depression

The mean score on the depression measure (PHQ-9) was 14.4 (SD7.1), which is at the high end of the moderate range. More than half of the Men (58%) fell into the moderately severe or severe range of depression; 15% were in the moderate range; 15% were in the mild range, and 13% fell into the normal range.

Of the participants who had at least mild depression on the PHQ-9 (n=135), 87% said that their depression was making it 'somewhat', 'very' or 'extremely' difficult to do their work, take care of things at home, or get along with other people.

Almost all (99%) reported that they had experienced another period where they felt down, had difficulty in cheering up, or lost pleasure in everything for a period of at least two weeks. Almost one-third reported that this had happened between the ages of 13 and 19 years. For 10% of participants, this had first occurred before the age of 12 years. More than half (55%) reported that they had experienced a period like this 10 or more times and 19% had experienced it four to nine times. More than half (55%) were currently receiving treatment for depression; 65% had previously had treatment for depression. Only 8% had never received treatment for depression, anxiety or stress.

Seventy per cent reported having had thoughts about suicide in the fortnight prior to participation: 36% on several days; 19% on more than half the days; and 15% nearly every day.

Current risk and previous history of anxiety

The mean score on the anxiety measure (GAD-7) was 10.5 (SD5.9), which is in the mild range. Almost half of the Men (49%) were in the moderate or severe range of anxiety; 36% were in the mild range and 15% were in the normal range.

Of the participants who scored at least mild on the GAD-7 (n=131), 83% said that their anxiety was making it somewhat, very or extremely difficult to do their work, take care of things at home, or get along with other people.

Almost all (92%) reported that they had experienced another period where they excessive worry more days than not. One-quarter reported that this had happened between the ages of 13 and 19 years. For 8% of participants, this had first occurred before the age of 12 years. Almost half (49%) reported that they had experienced a period like this 10 or more times and 19% had experienced it four to nine times.

One third (35%) were currently receiving treatment for anxiety; 47% had previously had treatment for anxiety; 22% were currently receiving treatment for stress; 32% had previously had treatment for stress.

Strategies for dissemination of information

The following strategies, in order, were endorsed as the most effective ways to get information to men who are suicidal: high profile men talking in the mainstream media about their experience of depression and suicidality; an ad campaign directed at men, using social media to distribute information, and having a central online source of information about depression and suicidality (Table 10).

Table 10: Best ways to get information and strategies to men who are experiencing depression or suicidality

Source	N	Percentage
High profile men in mainstream media	93	53
Ad campaign directed at men	80	46
Facebook or other social media	76	43
Central online source of info	70	39
Education campaign through GPs	51	20
Online ads	31	18
Other*	31	18
Online chat rooms	20	11

Other dissemination strategies suggested by Men include the following: work place advocacy programs to improve mental health literacy and reduce stigma; develop targeted mental health programs specifically for men, including more personal sessions with groups of men; create support groups for men and partner with existing community based organisations; hold education and awareness events at community organisations (e.g. Men's Sheds, sporting groups); education campaigns emphasising that other people have sought help and their mood has improved; and focus on education in schools and universities by teaching life-skills, coping skills, self-awareness and resilience.

One man highlighted the need for reaching men with disabilities, by using 'leaders' across and range of sectors and not just 'high profile men', while others emphasised the importance of reaching men in as many varied ways as possible.

In contrast, one man reported he had no ideas about the best way to reach other men, while another expressed doubt that any of the suggested strategies would work at all.

Key findings:

Effective strategies are needed to disseminate information about male suicide and depression. The most frequently endorsed suggestions included:

- having high profile men talk in the mainstream media about their experience of depression and suicidality;
- aiming an awareness campaign directly at men; and,
- contacting men using social media (e.g. Facebook)

2.2.2 Results of Family and Friends Survey

Demographic profile of respondents

One hundred and eighteen Family and Friends completed the online survey.

The median age of Family and Friends was 38 years (range 18-67). Three quarters (78%) were female; 59% were married or in a de facto relationship; three quarters (78%) were employed and 10% were either unemployed or unable to work, with the remainder being engaged in home duties, care giver duties, study, or retired. More than one-third 37% had completed a university degree or higher (Table 11). The majority (89%) rated their health as good, very good or excellent, with 11% rating their health as fair or poor.

Table 11: Characteristics of Family and Friends (n=118)

Characteristics	Percentage
Demographics	
Married/de facto	59
Employed	78
Aboriginal/Torres Strait Islander status	1
Highest level of education	
Year 12	17
Trade or diploma	46
University degree or higher	37

Warning signs observed by family and friends

Similar to the findings for the Men's survey, the change most frequently observed by Family and Friends when a man was depressed or suicidal was a drop in self-care, followed by changes in emotional state (easily upset or irritable) and loss of interest in everything. The least frequently nominated change was telling others how he was feeling or saying goodbye to the people close to him (Table 12).

Table 12: What changes did you notice when your friend or family member was depressed or suicidal (n=100)

Changes	Strongly agree %	Agree %	Neither agree nor disagree %	Disagree %	Strongly disagree %
He was not eating well or taking care of himself	47	31	11	8	3
He was flustered, easily upset	45	29	12	14	0
He lost interest in pretty much everything	44	33	12	10	1
He was irritable, particularly with family	40	35	12	10	3
He was sleeping more or less than usual	39	32	21	6	2
He was more aggressive towards others	32	28	15	20	5
He was drinking more alcohol	31	16	12	25	16
He was taking more risks, e.g. driving faster	28	20	22	24	6
He was on autopilot, doing things without thinking about it	25	33	27	14	1
He shut himself away	23	29	20	23	5
He was using more drugs	19	19	16	21	25
He told me or others how he was feeling	15	28	12	28	16
He said goodbye to the important people in his life	4	15	19	35	27

Barriers to help seeking

Respondents were asked to nominate which factors got in the way of getting help for their male friend or family member. The man's withdrawal emerged as a common theme (Table 13). Very few respondents didn't know that help was available, and few nominated fear of hospitalisation as a barrier. Only 12% were able to get help for their loved one.

Table 13: What got in the way of helping him

Barrier	n	Percentage
He had distanced himself from everyone	57	50
He wouldn't talk to me or let me help	47	42
I didn't know that things were so bad for him	39	35
He kept saying nothing was wrong	37	33
The services we tried weren't helpful	27	24
I thought I was part of the problem not the solution	26	23
The hospital wouldn't keep him in or put him on a community order	22	20
I didn't know how to approach him – i was worried I'd make it worse	20	18
I was afraid to use the words suicide or dying	16	14
There are very few services available in our area	16	14
I thought about calling the ambulance or police but I didn't want to...	16	14
I was worried that if I told someone that he wouldn't talk...	14	12
Nothing – I was able to get him help	13	12
I found it hard to accept that he was suicidal	11	10
I didn't realise there was somewhere we could get help	9	8
I was worried if I told someone he might be hospitalised	6	5
Other*	31	27.4

*Free text responses provided about barriers to their male friend or family member receiving help included the following: man threatened self-harm if privacy was not respected; man had comorbid issues that were not concurrently treated; lack of access to treatment services while still using drugs; poor services; not taking medication (due to a variety of reasons including personal choice, or influence of close friends/family); inability of family/friends to recognise when symptoms were severe and life-threatening; early discharge from emergency services; man's ambivalence regarding family and friends' attempts to help; costs and waiting lists for services; services unavailable during certain hours; increasing isolation and withdrawal by their male friend or family member.

Interrupting and preventing suicide

When asked which factors interrupt a suicide attempt, 89% of respondents said it was important or extremely important to let him know that he is valued and loved no matter how bad he feels (Table 14). Almost as strongly endorsed were early intervention and letting him know that you won't be fazed by what he tells you. Direct questioning and asking for an honest response where also strongly endorsed, as were bringing together key people to work out a safety plan and helping the man to solve some problems. Indeed, only one strategy (getting him to do something that is totally engrossing) was not strongly endorsed.

Table 14: What interrupts a suicide attempt?

	1 Extremely important	2	3	4	5 Not at all important
Letting him know that he is valued and loved no matter how bad he feels	72	17	4	6	1
Intervening as soon as you notice a change	64	20	12	2	1
Letting him know that he can tell you anything and that you won't be fazed	64	21	12	1	1
Letting him know that there is a way through and you'll be there	60	20	10	8	2
Telling him that you need him to be honest about what's going on	59	19	13	7	2
Asking him straight out if he's having thoughts about dying or killing himself	56	19	20	3	2
Bringing key people together and working out a plan to keep him safe	51	29	17	3	0
Helping him to see how he can solve some of his problems	48	27	13	9	3
Get him into a healthy routine, e.g. exercise, employment, social activity	47	30	17	6	1
Encouraging him to start eating, showering, moving around	44	22	20	13	0
Making observations that help him open up	44	19	17	13	7
Normalising what he is going through	43	28	19	7	3
Asking him what help he needs and following up	43	24	19	11	1
Spending a lot of time with him	34	34	22	4	4
Gently challenging his self-critical thoughts	34	30	27	7	2
Finding some ways to slow his brain down	30	33	21	9	7
Getting him to do something that is totally engrossing, e.g. skating, football match	19	28	28	20	6

Key findings:

- For Family and Friends, the three most commonly noticed warning signs included:
  - a reduction in self-care;
  - becoming easily upset and flustered; and,
  - a loss of interest in 'pretty much everything.'
- The most commonly reported barriers to help-seeking were:
  - increased distance and withdrawal;
  - refusal of offers to talk or help; and,
  - lack of awareness that something was wrong.
- Family and Friends rated the following as 'extremely important' strategies to interrupt a suicide attempt:
  - actively communicating and reinforcing a man's value;

- intervening immediately; and,
- providing a 'safe' space to disclose.

Strategies for dissemination of information

The channels and methods identified as effective in getting information to men were similar to those identified by the Men themselves: having high profile men speak in the media about their experience of depression and suicidality and an ad campaign directed at men, followed by having a central online source of information about depression and suicidality.

Table 15: Best ways to get information and strategies to men

Source	N	Percentage
High profile men in mainstream media	68	60
Ad campaign directed at men	66	58
Central online source of info	54	48
Information that is humorous, direct and normalises what he is going through	52	46
Facebook or other social media	49	43
Education campaign through GPs	47	42
Online ads	24	21
Online chat rooms	12	11
Other	12	11

*Free text answers with other dissemination strategies suggested by Family and Friends include the following: discussions at community health centres and libraries; educating society so that men in distress around surrounded by people who understand; more information and education about severe PTSD and the high risk of suicide; 'more things for men and suicide like group sessions'; better services, reliable services and more services; breaking down male stereotypes and stigma; advertising programs during major sporting events; providing more information and support for family and friends so they are better equipped to help.

We note than one Family and Friends participant voiced some hesitation that public messages would have reached their male friend or family member "*because he was so closed off…".*

Current depression and anxiety

The mean score on the PHQ-9 was 8.8 (SD 7.2), which is in the mild range. One-fifth of participants were in the moderately severe to severe range for depression; 14% were in the moderate range, 30% were in the mild range and 35% were within the normal range. Of the 75 participants who scored at least mild on the PHQ-9, 73% said that their depression was making it 'somewhat', 'very' or 'extremely' difficult to do their work, take care of things at home, or get along with other people.

The mean score on the GAD-7 was 2.4, which is in the normal range. Thirty per cent of participants were in the moderate or severe range; 31% were in the mild range and 39% were within the normal range. Of the participants who scored at least mild on the GAD-7 (n=76), 63% said that their anxiety was making it 'somewhat', 'very' or 'extremely' difficult to do their work, take care of things at

home, or get along with other people. Seventeen per cent were currently receiving treatment for anxiety; 30% had previously had treatment for anxiety; 8% were currently receiving treatment for stress; 20% had previously had treatment for stress; 24% were currently receiving treatment for depression; 35% had previously had treatment for depression.

CONCLUSION

The project team has completed an extensive investigation into the experiences of men with suicidal behaviour and the views of their family and friends. We note the following points in relation to both the practical logistics of conducting research in this population and the findings themselves:

Practical considerations for conducting research with depressed or suicidal men and family and friends

Recruitment of participants for face-to-face interviews and focus groups was extremely difficult due to the sensitive nature of the subject matter and the fact that suicide attempts are often hidden from family and friends. Clinical psychologists who were prepared to assist with participant recruitment and provide support during interviews and focus groups were also difficult to find. Recruitment of participants to Phase 2 online surveys was somewhat easier. Achieving research of this type requires contacting hundreds of people, and fostering strong relationships with service providers, active stakeholders and motivated community members in order to reach and communicate with members of an affected community that is characterised by a strong need for privacy. The study team achieved this through continual proactive communication and the allocation of additional resources beyond the grant budget, with Phase 2 recruitment no doubt benefitting from the relationships established during Phase 1. These relationships allowed the study team to make contact with target audiences in all states and territories of Australia; it was then possible to earn the trust of participants who shared their intimate life experiences, in a setting which they later reported as being 'safe' to do so.

Despite the sensitive and potentially distressing nature of the research, people deeply appreciated the opportunity to tell their story and to be listened to. Many of the Phase 1 participants who provided written feedback at the close of the interview or discussion found the research process to be therapeutically beneficial. They reported that the interviews and focus group discussions helped to order and clarify their thinking through a process of reflection and discussion with another or others. In doing so, they found the opportunity to potentially contribute to the wellbeing of others incredibly rewarding. This echoes previous research on interviewing vulnerable populations about sensitive topics (Biddle et al 2013). Far from causing distress, many participants indicated that the process was cathartic, and any distress they may have experienced through the discussion of old traumatic events was outweighed by the satisfaction of having contributed to something they felt was meaningful and valuable.

Considerations arising from the results

There were some strong similarities in results from each phase of data collection. For example, in Phase 1, depressed moods interacting with a set of 'stoic' beliefs about masculinity led many Men to use ineffective coping strategies like isolation and withdrawal, often while feeling that their situation was hopeless. This was echoed among the Men in Phase 2, where the most frequently nominated barriers to receiving help were having isolated one's self from everyone, not wanting to be a burden to others, a tendency to bottle up feelings and a sense that things seemed hopeless. Similarly, Men in Phase 1 reported that a sense of responsibility and obligation towards their family, including their children, was a key factor in interrupting suicidal behaviours. This was heavily endorsed by the larger sample in the online survey, where 64% of Men strongly agreed that one thing stopping them from attempting suicide was thinking about the consequences for their family. These similarities in findings between Phase 1 and Phase 2 imply that the contributing, interrupting and preventive

factors identified during Phase 1 are significant to this population, especially given that they clearly resonated with the much larger online survey sample.

A clear message arising from both Phase 1 and Phase 2 is that Men want others around them to notice changes in their behaviour, and correctly 'interpret' these changes (e.g. changes in mood, social withdrawal) as indicative of a spiralling mood, or an increased risk of suicidal behaviour. In addition, Men reiterated that successful intervention depended on being asked multiple times whether they were OK, and that they valued hearing repeatedly that people around them cared.

During Phase 1, Family and Friends reported the warning signs they generally witnessed were destructive, externalising, and numbing behaviours, such as aggression, risk taking and substance use, while during Phase 2, Family and Friends noticed reductions in self-care and losing interest in 'pretty much everything' . However, in addition to these signs, Family and Friends noticed attempts by men to re-engage with their family. Family and Friends reported that they often wanted to help, but were often unsure how to respond to men's warning signs. There is clearly great need for interventions that address these gaps in knowledge and communication, particularly in light of the fact that Men reported needing repeatedly to be asked how they are and be told how much they were valued and loved by people close to them whom they already trusted and respected.

Awareness raising and education are needed to assist the community in general as well as the Family and Friends of Men who are at-risk of suicide to better recognise the signs of suicidality in men. Education that focuses on how to better recognise signs of suicidality in men, paired with training on how to respond to these signs and intervene effectively during times of suicidal crisis should be prioritised. Training should emphasise the varied and broad range of warning signs exhibited by different men at different stages of suicidality, and not just focus on traditional symptoms of a depressed mood. This would include increased awareness of common 'externalising' and risk-taking behaviours exhibited by men during the pathway to suicide. As men tend not to ask for help, assistance is needed to guide family and friends on how and when to approach a man at-risk, what to say, when to refer to a mental health professional, and how to manage the situation if the latter is against his wishes.

In addition to involving family and friends in suicide prevention with at-risk men, health professionals play an important role in recognising the warning signs, and taking action to prevent and interrupt a suicide attempt. They are uniquely placed to intervene with men who present with anger and externalising behaviours, such as in clinics, hospitals and in general practice. Consultations with practicing clinicians on the best way to incorporate findings from this research into practice are an essential step. For example, identifying appropriate times to conduct suicide assessments, based on non-traditional warning signs identified here may help to prevent men from proceeding further down a self-harm pathway. Likewise, clinicians are appropriately positioned to help men in crisis develop skills to better cope with mental health issues. Men reported that they had developed few skills in experiencing, tolerating and communicating emotions, and this directly led to engaging in other unhelpful coping strategies. Isolation exacerbated their low moods, and propelled them further down the pathway. Better skills training for men in emotion identification and regulation could assist them to choose alternative and more helpful strategies to manage their mood, and to limit the extent of their distress.

Men and Family and Friends who participated in this research endorsed very similar dissemination strategies: high profile men talking in the mainstream media about their experience of depression and suicidality; an ad campaign directed at men, using social media to distribute information, and having a central online source of information about depression and suicidality. Men and Family and

Friends clearly identified the need for greater awareness of the issues involved, highlighted that men need to hear from other men that they are not alone, and both agreed that there needs to be readily-available resources for people to turn to in times of crisis. The reach and effectiveness of such campaigns are necessarily dependent on both continued investment and identification of messages appropriate to reaching men at-risk of suicide.

A clear difference between the Phase 1 and Phase 2 findings is the difference in the severity of current depressive symptoms. The majority of Phase 1 Men (60%) reported mild or no depression, while the majority of Phase 2 Men (58%) reported moderate to severe depression. A similar, less pronounced difference was observed between Phase 1 and Phase 2 Family and Friends (mild or no depression: 81% versus 65% respectively). We note that recruitment approaches were similar for each phase of data collection (i.e. publicising the study via the Black Dog Institute, clinicians, organisations, community members), yet the two data collection phases attracted groups experiencing depression to a different degree. Thus, the results show that recruitment of severely depressed and/or suicidal participants to research projects is possible, particularly to online studies, which may even be preferable. Moreover, it is interesting to note that despite differences in depression severity between the two phases of data collection, the reported findings were markedly similar in each phase, indicating that the relevant contributing, preventing and interrupting factors identified at each phase do not differ according how depressed a person is feeling at the time.

Lastly, we have clearly described a context in which interventions aiming to interrupt or prevent suicide among men are subject to a number of tensions that must be negotiated in order to be successful. It is clear from our results that it will not be a simple process, yet these dichotomies must be balanced in order to ensure that men receive help and support that is flexible enough to meet their needs and appropriate to the level of risk men may be experiencing. Men and Family and Friends in this study testified that interrupting suicide attempts and receiving appropriate help often resulted in them experiencing closer bonds and greater emotional awareness in their relationships.

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APPENDIX 1: FINANCIAL STATEMENT

UNSW AUSTRALIA

ABN 57 195 873 179

STATEMENT OF INCOME AND EXPENDITURE
FOR THE PERIOD
1 October 2013 to 1 December 2014

TITLE: Men's Experiences and Suicide - men's experiences with suicidal behaviour and depression

PROJECT MANAGER Proudfoot,Judy

PROJECT NO: RG134252

Life to Date $		$	Current Period $
0.00	**OPENING BALANCE UNSPENT/(OVERSPENT)**		0.00
	OPERATING INCOME		
80,000.00	Grant received	80,000.00	
9.26	Interest	9.26	
80,009.26	* **TOTAL OPERATING REVENUE**		**80,009.26**
	OPERATING EXPENDITURE		
47,222.15	Salaries	47,222.15	
0.00	Equipment	0.00	
44,017.80	Materials / Supplies	44,017.80	
0.00	Scholarships	0.00	
8,757.05	Travel	8,757.05	
99,997.00	**TOTAL OPERATING EXPENDITURE**		99,997.00
(19,987.74)	**CLOSING BALANCE UNSPENT/(OVERSPENT)**		**(19,987.74)**

	COMMITMENTS OUTSTANDING AT PERIOD END		
	Salaries		
	Equipment		
	Supplies		
	Scholarships		
	Contract services		
	Travel		
	Others		
0.00	**TOTAL COMMITMENTS OUTSTANDING**		**0.00**

Unpaid Invoices (including GST): **0.00**

CONFIRMED TO UNSW LEDGER Saparamadu

Marie Saparamadu CPA, ACMA, CGMA
Snr Manager
Research Finance Office
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* Where GST has been received in addition to the grant funds above, the GST has been forwarded to the Australian Taxation Office.

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