Understanding suicide and developing realistic prevention strategies

Anne Cleary, UCD Geary Institute for Public Policy

Introduction

Suicide has been designated as a critical public health problem by the World Health Organisation (WHO 2014) as well as by successive Irish governments since the 1990s. According to the WHO (2022), more than 700,000 people die each year by suicide representing one in ten deaths worldwide and the figure is considerably higher for younger age cohorts. Until the 1970s, Ireland experienced a relatively low suicide rate but over three decades, levels increased significantly, peaking in the late 1990s. Thereafter, the rate stabilised until the recession years 2009-2013 when an increase in suicide occurred and this was followed by successive decreases in rates (Figure 1; HSE/NOSP 2021). In terms of the global prevalence of suicide, Ireland ranks in the middle tier of countries and has a relatively low rate compared to other European countries (Figure 2; HSE/NOSP 2021). In 2020, 340 deaths were categorised as suicide in Ireland which represents a rate of 6.8 per 100,000 of the population of which 259 were male (a rate of 10.5 per 100,000 of the population) and 81 were female (a rate of 3.2 per 100,000 of the population) (HSE/NOSP 2021). These data demonstrate the considerable gender differential that exists in relation to suicide with the male rate approximately four times higher than that of the female rate, although the ratio has reduced slightly in recent times. This trend is in line with many other Western countries but internationally male/female ratios, as well as overall suicide rates, vary significantly, which denotes the impact of sociocultural factors on suicide.

Despite the attention paid to suicide in terms of research and public health interventions in Ireland and elsewhere, comparatively little is known about suicidal action. The relative infrequency of suicide along with the methodological and ethical difficulties of researching the topic have presented particular challenges in deciphering the suicidal process, enumerating risk and developing effective interventions. This paper examines the topic of suicide in Ireland and national policy responses to the issue, drawing on the findings of a study of men who made a near-fatal or clinically serious suicide attempt and two follow-up investigations of these men.

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

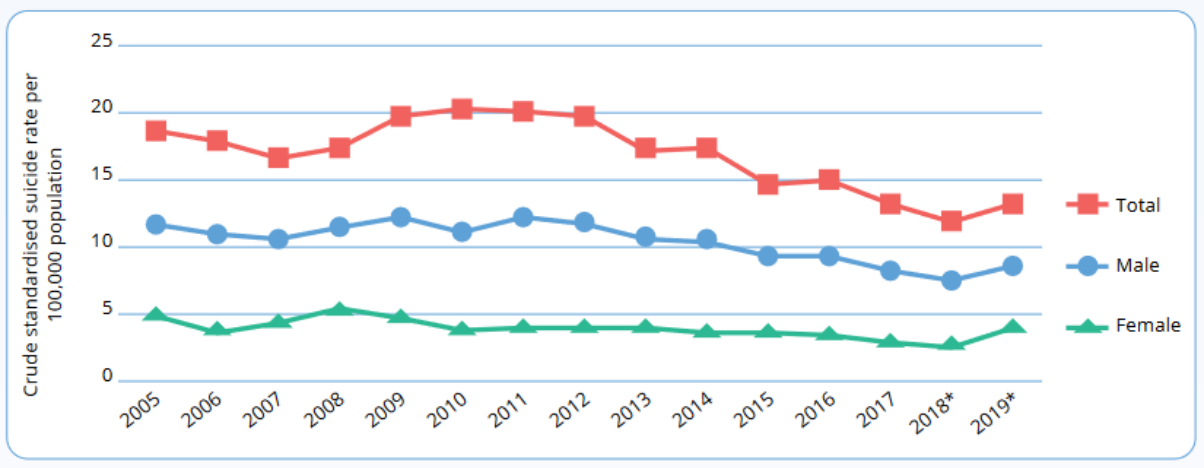

Figure 1: Crude standardised suicide rates per 100,000 of the population over the period 2005-2019 (*denotes data as provisional). Source: Central Statistics Office, cited in HSE/NOSP (2021)*

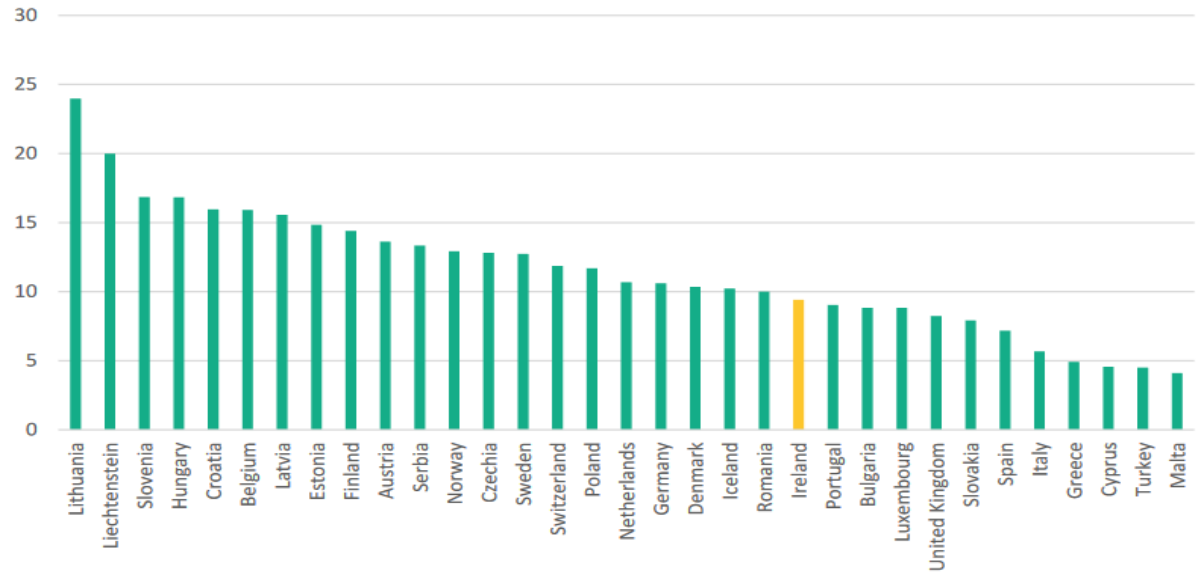

Figure 2: Suicide rates per 100,000, all ages, 2018. Source: HSE National Office for Suicide Prevention (2021)

A study of suicidal action and outcome

Methodology

This series of studies included a baseline, qualitative, investigation of men who made a near-fatal or clinically serious suicide attempt who were interviewed in hospital after the action and subsequently followed up at two points (seven years and fifteen years) using hospital and out-

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

patient records and Central Statistics Office (CSO) data relating to suicide deaths (Cleary 2019). A small number of interviews were also carried out at the 7-year follow-up stage. The research was carried out in University College Dublin funded by the Irish Research Council, the National Disability Authority, and the Fulbright Commission. Ethical approval was obtained from the individual hospitals and, in relation to accessing CSO data, this involved gaining permission from the Department of Health and the CSO and the author becoming an Officer of Statistics to legally protect the information. The aim of the original research project was to understand suicidal action from the perspective of those who attempted to take their own lives and the follow-up inquiries sought to ascertain outcome in terms of future suicide attempts and contact with the health services. The baseline study involved a consecutive sample of fifty-two men, aged 18-30 years, admitted to three major hospitals in the Eastern region, who fulfilled the criterion of a clinically serious suicide attempt. All interviews were carried out by the author and an entirely open-ended schedule was used to allow subjective construction of the suicide attempt. Interviews were audio-taped and thematic analysis of the narratives produced patterns related to the action as well as the motivations and background factors involved (Cleary 2019).

Findings

The study participants, who came predominantly from lower socio-economic backgrounds, produced accounts which were contrary to many existing ideas about the process and causation of male suicidal behaviour. The findings indicated that suicide is rarely an impulsive action - a major element of clinical theories of suicide - and that a more realistic scenario is one of long-term difficulties wherein the suicidal process is accelerated by a negative event or situation. Many had experienced trauma and/ or adversity in childhood and the resultant distress became more embedded as they grew and affected their ability to cope with the issues of their lives. These matters had remained unresolved due to family difficulties and because of the way that masculinity was understood and practiced in their social environment. Traditional concepts of masculinity, emphasizing strength and emotional stoicism, were instilled early in their lives within the family and enforced in the wider community, especially in school, and this milieu impeded them in speaking about painful experiences, and from accessing help. These emotionally restricted environments fostered the denial and suppression of culturally unacceptable emotions, and alcohol frequently provided an approved form of masking problems which prolonged the men's suffering and placed them at greater risk of suicide (Cleary 2012). The extent of concealment in the study helps to decipher the paradox of higher rates of reported distress for women but higher levels of completed suicide for men. In adulthood, ideas about suicide began to form as distress accumulated, often in response to a triggering event and was exacerbated by concealment and a lack of resources to deal with the situation. These precipitating events frequently involved relationship issues, which contrasts with conventional views about male suicide i.e. that men are more likely to end their lives for economic or employment-related reasons (Canetto 1993). In this and other ways, the men's narratives did not align with stereotypic views about male suicidal behaviour and men's emotions. Emotions, particularly sadness, and unfulfilled emotional needs featured prominently in their stories. They sought emotionally responsive relationships with fathers and

with partners and experienced intense sorrow when this was denied or lost and, contrary to gendered theories of behaviour, these men channelled painful emotions internally and much less frequently in external ways via aggression and violence.

Follow-up studies

The study participants were followed up at two points, at seven years and at fifteen years, after the initial interview, using hospital records and CSO data relating to deaths by suicide. A small number of men were re-interviewed at the seven-year stage. At the seven-year point, half (n=26) of the men had made a further suicide attempt and six of this group had died by suicide. When the remaining men (n=46) were tracked fifteen years after the baseline interview, two further men had completed suicide. This repetition rate is comparable to other studies (Hawton & van Heeringen 2009) but the level of completion (15.4%) is higher than in similar investigations (Beautrais 2003; 2004). In general, the study participants had not engaged with the post-hospitalisation treatment offered by the mental health services. One-third of the men failed to attend a scheduled post-discharge appointment and only a small minority of the others maintained contact with the services after this initial appointment (Cleary 2017).

Three groupings emerged from the follow-up investigations – the non-repeat group, the repeat-survivor group, and those who completed suicide, and there were important differences between the categories. The non-repeat group had relatively stable lives and comparatively good resources including higher educational attainment and steady employment, compared to the others, but they had backgrounds which made them insecure and the suicide attempt was almost always preceded by an event which had negative meaning for them (Cleary 2019). Those who repeated and survived consisted of men who made one further attempt and those who made multiple suicide attempts. The first group resembled the non-repeat category in terms of background factors and the subsequent suicidal action generally occurred soon after the original attempt, which might imply that they required a longer adjustment period. Survivors who made a number of further suicide attempts tended to have additional problems such as drug or alcohol dependency but also included men with a serious psychiatric illness, none of whom completed suicide although they had very high rates of repetition during the follow-up period. The fact that they had regular contact with the mental health services was probably a protective factor for this high-risk group.

The category of men who completed suicide, although a relatively small number (n=8), contained two distinct groupings. The larger group contained men who were slightly older than the other study participants and tended to have a history which included an accumulation of negative features from an early age, notably risk behaviour and alcohol dependency. When interviewed for the baseline study, they expressed little confidence in treatment interventions and generally coped with rising levels of distress by intensifying their alcohol consumption and aggressive behaviour. They indicated that their options were diminishing and that support systems were weakening due to their behaviour and spoke of ending their lives as an inevitable and even comforting prospect. The second group of men who completed suicide had a very different profile as, at surface level, they appeared to have relatively stable lives and good

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

levels of support. Yet, they felt constrained, more accurately trapped, in the lives they lived and found the normative masculinity particularly challenging but felt unable to break away from this, for example, by leaving the locality or expressing their sexuality, steps which other participants had taken following the initial suicide attempt (Cleary 2019).

This research demonstrates the influence of social environments and cultural circumstances on suicidal behaviour and highlights particular subgroups of men and specific practices which require attention in terms of suicide prevention. Individual differences were apparent in that each case featured a unique individual who had experienced life in a distinct way but it was clear that these men drew on cultural, including gender, guidelines for their behaviour and patterns relating to the suicidal actions were identifiable. Risk was associated with lower socio-economic status which in this investigation resulted in less opportunities and choices in relation to one's life, and to cultural, specifically gender, constraints which prevented men from expressing their emotional needs. In this way, young men who lack socio-economic resources and who are constrained by models of masculinity that inhibit the expression of distress, are more likely to attempt and complete suicide.

Policy developments and prevention strategies relating to Suicide in Ireland

The first national policy document relating to suicide in Ireland was published in 1998 (DOHC 1998), based on the recommendations of a National Task Force on Suicide set up to address a steep rise in Irish suicide rates (DOH 1996). The Task Force linked rising levels of suicide in Ireland to factors such as mental illness, social change and isolation and noted the methodological challenges of studying suicide as well as a cultural reluctance to address the issue at that time (suicide was decriminalised in Ireland in 1993). The subsequent national strategy (*Reach Out: National Strategy for Action on Suicide Prevention 2005-2014*; DOHC/HSE 2005) sought to address gaps in the implementation of this policy and advocated a general population approach which promoted positive mental health while targeting high-risk groups. The most recent policy document - *Connecting for Life: Ireland's National Strategy to reduce suicide 2015-2020* (DOH/HSE 2015), now extended to 2024, continued this broad-based as well as targeted methodology but advocated a more co-ordinated, multi-agency, approach to suicide prevention. This two-level strategy has been the basis of public health messaging and action in relation to suicide over the last decade. The public health messaging has contributed to developing a national conversation about mental health and suicide, particularly in relation to men, and may have contributed to the decrease in suicide rates witnessed in recent years (HSE/NOSP 2021; NOSP 2019). Yet, rates remain relatively high amongst many at-risk categories.

There is a need for attention to be paid to the issues raised in this research project as this could improve the efficacy of preventive methods. While the most recent national strategy refers to the impact of social factors in suicidal behaviour, interventions tend to be organised within existing discourses and structures, for example with reference to medical diagnoses and

improving existing mental health services. However, suicide has moved increasingly outside the clinical domain and a significant number of individuals who complete suicide are not in contact with the services and do not have a psychiatric diagnosis (Owens et al. 2003), which was true of the men in this research. This might be envisaged by some clinicians as unmet need but the fact that a seemingly cathartic event, a near-fatal suicide attempt, did not induce these participants to engage with treatment raises questions about this type of intervention. These men did not seek treatment because they did not frame their problems within an illness discourse and/ or the therapies on offer did not appeal or were perceived as stigmatising for men. An intervention which allowed these men a space to explore the issues of their lives would, and did, help some individuals, but such an intervention does not necessarily have to occur within the structured mental health services and accessing a different social and emotional space appeared to have a positive impact on outcome (Cleary 2019).

The health services do have an important part to play in suicide prevention, in supporting high risk groups such as those with serious mental illness, providing early interventions for alcohol dependency and directing those who attempt suicide towards appropriate interventions. Primary care and hospital Accident and Emergency Departments are critical settings for identifying at-risk men but these individuals do not always fit with standardised suicide risk indicators. They may obscure their distress or make inadvertent appeals for help, as they did in this study, and health professionals need to be skilled in recognising relevant features. The link between completed suicide and lower socio-economic status requires attention as these findings show how socio-economic status interacts with other factors, especially educational opportunities, to increase or decrease suicidal risk. Gender remains a key explanatory variable but the concept requires more nuanced and accurate insertion into health messages and interventions. A prevailing narrative frames all males as susceptible to suicide but male groupings vary greatly in terms of resources and in their attitudes to health and in terms of suicide risk. The findings of this research challenge simple dualistic categorisations of male and female emotions and imply that cultural ideas about gender appropriate ways to feel and to express emotions are more pertinent issues. Public health messaging needs to replace simplistic binary and singular ideas about emotions with more realistic concepts as well as introducing conversations about relationships and the benefits of emotionally engaged fathering for boys.

Cultural and subcultural norms influence who will move towards suicidal action and particular groups have specific prevention and intervention needs which may be time-sensitive such as for LGBT individuals during adolescence (Russell and Toomey 2012). Health-related messages and initiatives need to be grounded in local knowledge and assisted by local influencers. Campaigns which appeal to men to abandon particular masculinity beliefs and practices are unlikely to be effective without local knowledge and input. More generally, the research reported in this paper implies that better outcomes are likely from interventions grounded in the reality of suicidal behaviour and when these interventions are evaluated to assist future strategies.

References

Beautrais, A.L. (2003) Subsequent mortality in medically serious suicide attempts: a 5 year follow-up. *Australian and New Zealand Journal of Psychiatry* 37, 595-599. https://doi.org/10.1046/j.1440-1614.2003.01236.x

Beautrais, A.L. (2004) Further suicidal behaviour among medically serious suicide attempters. *Suicide Life Threat Behav*, 34(1), 1-11. https://doi.org/10.1521/suli.34.1.1.27772

Canetto, S.S. (1993) She died for love and he for glory: Gender myths of suicidal behaviour. *Omega: Journal of Death and Dying*, 26(1), 1-17. https://doi.org/10.2190/74YQ-YNB8-R43R-7X4A

Cleary, A (2019) The gendered landscape of suicide: Masculinities, emotions and culture. Palgrave Macmillan.

Cleary, A. (2017) Help-seeking patterns and attitudes to treatment amongst men who attempted suicide. *Journal of Mental Health*, 26(3), 220-224. https://doi.org/10.3109/09638237.2016.1149800

Cleary, A (2012) Suicidal action, emotional expression, and the performance of masculinities. *Social Science & Medicine*, 74, 498-505. https://doi.org/10.1016/j.socscimed.2011.08.002

Department Of Health (1996) National Task Force on Suicide: Interim Report. Dublin, Stationery Office. https://www.drugsandalcohol.ie/5213/

Department of Health and Children. (1998) Report of the National Task Force on Suicide Final Report. Dublin, Stationery Office. https://hdl.handle.net/10147/44572

Department of Health/HSE (2015) Connecting for life: Ireland's National Strategy to Reduce Suicide 2015-2020. Ireland, Department of Health/HSE/NOSP. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/connecting%20for%20life.pdf

Hawton, K., & van Heeringen, K. (2009) Suicide. *The Lancet*, 373(9672), 1372-1381. https://doi.org: 10.1016/S0140-6736(09)60372-X.

HSE/NOSP (2021) HSE National Office for Suicide Prevention (NOSP): Briefing on Eurostat Suicide Comparisons 27th July 2021. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/nosp-briefing-on-suicide-figures.html

HSE/NOSP (2021) A Review of research carried out as part of Connecting for Life. April 2021. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/synthesis-report.pdf

Department of Health and Children/HSE (2005) Reach Out: National Strategy for Action on Suicide Prevention 2004 2014. Ireland, Health Service Executive. https://health.gov.ie/wp-content/uploads/2014/03/reach_out.pdf

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.

National Office for Suicide Prevention (2019) Connecting for Life: Interim Strategy Review. An Independent Review of Implementation Progress by Strategy Leads. Ireland, National Office for Suicide Prevention. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/cfl-interim-strategy-review.pdf

Owens, C., Booth, N., Briscoe, M., Lawrence, C., & Lloyd, K. (2003). Suicide outside the care of mental health services: A case-controlled psychological autopsy study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 24*(3), 113–121. https://doi.org/10.1027/0227-5910.24.3.113

Russell, S. T. and R.B. Toomey (2012). Adolescent sexual orientation and suicide: Evidence for US adolescent-specific risk. *Social Science & Medicine*, 74(4): 523-529. https://doi.org 10.1016/j.socscimed.2010.07.038. Epub 2010 Sep 15

World Health Organisation (2014). Preventing suicide: A global imperative. Geneva. WHO https://www.who.int/publications/i/item/9789241564779

World Health Organisation (WHO). https://www.who.int/publications/m/item/steps-mental-health-suicide-module, accessed May 9th 2022.

UCD **Geary Institute** for Public Policy, University College Dublin, Belfield, Dublin 4, Ireland. Phone +353 1 716 4615 Website: https://www.ucd.ie/geary Email: geary@ucd.ie.