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## What interrupts men's suicide? Results from an online survey of men

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Title: What interrupts men’s suicide? Results from an online survey of men

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## ABSTRACT

### Objective

Men are almost two times more likely to die by suicide than women, yet little research has focussed on what is required to prevent suicide amongst men. This paper aims to investigate what factors interrupt suicidal behaviour in men, and to examine differences according to known suicide risk factors.

### Method

As part of a mixed method study investigating men's experiences of depression and suicidality, an online survey was conducted with men who had made a suicide attempt. The survey canvassed the language men use to describe their depression and suicidality, warning signs, barriers to accessing help, and what is needed to interrupt a suicide attempt. Odds ratios and Chi-square were used to test for differences by age, geographic location, and depression severity.

### Results

Of 299 men screened and eligible to participate, 251 completed all or part of the survey. Participants identified different words and warnings signs for depression compared with suicidality. The most commonly endorsed barriers to accessing help were not wanting to burden others and having isolated themselves. Men overwhelmingly endorsed 'I thought about the consequences for my family' as the factor which stopped a suicide attempt, along with 'I need support from someone I really trust and respect'. There were few differences by age, region or depression severity.

### Conclusion

Participants were able to identify signs, albeit often subtle ones, that they were becoming depressed or suicidal. Similarly, most were able to identify active strategies to interrupt this downward spiral. Men wanted others to notice changes in their behaviour, and to approach them without judgement.

**Strengths:** This was a mixed methods study with substantial input from people with lived experience into the quantitative survey. **Limitations:** this was a convenience sample of participants and not a representative sample. These men may differ from other men, who did not see or respond to the survey, in important ways such as their coping strategies and suicidal intent.

INTRODUCTION

Around seventy-five per cent of suicide deaths in Australia are men. Suicide is the leading cause of death among Australian men aged 18 to 44 (1), and is particularly prevalent amongst men who are separated or divorced, unemployed, experiencing ill health, chronic pain, mental illness and substance use disorders.(2, 3) Globally, men are almost two times more likely to die by suicide than women, with inter-country ratios ranging from 0.9 to 4.1.(3) In Australia, men in regional and rural areas are particularly at risk.(4)

Although men have lower reported rates of mood and anxiety disorders, suicidal ideation and suicide attempts than women, they have higher rates of risk taking, impulsivity, and substance use disorders.(5) These are factors which put them at risk of progressing from suicidal thinking to a suicide attempt.(6)

Further gender differences are evident in help-seeking and coping strategies. Men seek help for depression and suicidality less often.(7) Of the men who reported a 12-month mental disorder in 2007, only 27 per cent sought professional assistance, compared with 41 per cent of women.(8) Suicidal males have a higher threshold for help seeking than women.(7) In the 12 months prior to suicide, fewer men than women sought help from a mental health professional or primary care providers.(9) Young women also have greater social support and are more likely to use it than young men, in addition to being more likely to ‘vent’ or turn to religion.(10) With increased isolation a risk factor for suicidality, seeking social support is likely to be an effective protective behaviour for women. One further difference likely to have a substantial impact on the gender difference in suicide deaths is men’s choice of more lethal means, which goes some way to explaining why women have more suicide attempts but fewer deaths.(11)

Despite the scope of the problem for men, little is known about how to prevent men’s suicidal behaviours or how to interrupt a man’s suicide attempt. Even less research has examined this issue from the perspective of those with lived experience (ref Lessons for Life, SANE). The current study aims to address this issue. Specifically, it aims to:

- 1) Investigate what factors interrupt suicidal behaviour and contribute to taking action during a suicidal crisis.
- 2) Examine differences according to known risk factors for death by suicide: regional or remote geographic location, older age, and higher depression severity.

## METHOD

### Design

As part of a mixed method study investigating men's experiences of depression and suicidality, two online surveys were conducted with (a) men who had made a suicide attempt in the previous six to 18 months; and (b) family or friends of men who had made a suicide attempt in the previous six to 18 months. Data reported here are from the men's survey only. The survey items were derived from themes emerging from phase one of the study, a qualitative project, where men took part in interviews and family and friends took part in focus groups examining what factors contribute to suicidal behaviour and depression and what interrupts suicidal behaviour (Player et al., submitted, cited with permission). The wording used for the questions and responses came from the language used by the men during their interviews.

### Participants

Participants were screened online and were required to be male, aged 18 or over, living in Australia, and to have had a suicide attempt in the past six to 18 months. This timeframe was chosen to ensure accurate recall on the one hand, and to minimise the risk that participants remained actively suicidal and vulnerable on the other. Participants were recruited through a national publicity campaign. The project was publicised nationally through our partner organisations beyondblue, Faces in the Street, and Mensheds Australia, and through the Black Dog Institute's website and social media channels (Facebook and Twitter), Lifeline, state and territory consumer and carer networks, mental health professional networks, and suicide prevention organisations. Ethics approval for the research was provided by the UNSW Human Research Ethics Committee (HREC 13077).

### Survey instrument and measures

The survey collected data on demographics (age; postcode; marital status, employment status, Aboriginal/Torres Strait Islander status, self-reported general health, and educational attainment). The presence and severity of depression was assessed using the Patient Health Questionnaire-9 (PHQ-9). The PHQ-9 is a nine item self-administered scale which assesses how often in the past two weeks participants have been bothered by a range of symptoms or problems.<sup>(12)</sup> Current level of depression used the

standardised PHQ-9 categories whereby 1-4 is minimal depression, 5-9 is mild, 10-14 is moderate, 15-19 moderately severe, and 20-28 severe. Anxiety was assessed using the Generalized Anxiety Disorder-7 (GAD-7) Scale. The GAD-7 is a seven item self-administered scale used to assess the severity of generalised anxiety by asking how often participants have experienced symptoms in the previous two weeks (13). Both scales have good reliability and validity.(12, 13) Current level of anxiety used the standardised GAD-7 categories where 0-4 is no or minimal anxiety, 5-9 is mild, 10-14 is moderate, and 15-21 severe. Participants were also asked if they were currently receiving treatment and/or had ever received treatment for depression, anxiety or stress.

For the online survey, the response categories for each question described below were drawn from the phase one interviews and focus groups. All questions allowed for an ‘other’ response followed by free text. Participants were asked to select a response to each of the following questions:

1. What words do you use to describe when you are feeling (a) down in the dumps; and (b) that life isn't worth living? (select all that apply).
2. What changes would people have seen when you were feeling really down and that life was not worth living? (the response scale was ‘strongly agree’ to ‘strongly disagree’ with ‘strongly agree’ and ‘agree’ dichotomised into ‘agree’ and all other responses coded as ‘disagree’).
3. When you were feeling down in the dumps, what got in the way of you seeking help? (select all that apply).
4. When you've felt that life was not worth living, what was it that stopped you from making a suicide attempt? (the response scale was ‘strongly agree’ to ‘strongly disagree’ with ‘strongly agree’ and ‘agree’ dichotomised into ‘agree’ and all other responses coded as ‘disagree’).
5. What else is needed to interrupt a suicide attempt? (the response scale was 1-5 with 5 being extremely important and 1 being not at all important, with 1 to 3 coded as unimportant and 4 to 5 as important).
6. In your opinion, what is the best way to get information and strategies to men and their family and friends? (select one or more options)

The survey was initially tested for length and clarity with a small number of participants. It was then modified and re-tested using the *Think Aloud Method*, which is designed to identify participants thought processes while they complete the survey. (14) Participants are asked to complete the survey and as they do so, to verbalise their thoughts, with a researcher listening to them 'thinking aloud' without being directly addressed by the participant. The researcher also observes the participant's non-verbal behaviours (sighing, pauses, slouching, taking a long time on a question, having to read a question more than once). This feedback was used to modify the survey before its release. The final survey was built and administered online using QuestionPro.(15)

### Participant safety

Screening excluded those who had made a suicide attempt in the past six months. People who were ineligible as well as any participants who were distressed could enter their contact details in order to be contacted directly by Lifeline, who were contracted to provide special follow up services for the study. Participants were asked at the beginning and end of the survey to rate their level of sadness, irritability, anxiety and agitation on a zero to 10 scale. A rating of 8 or more triggered a webpage expressing concern about their level of distress and where participants could enter their contact details to receive contact from Lifeline. The same page was triggered if participants scored in the severe range on the PHQ-9 or GAD-7, or indicated on PHQ-9 question 9 that they'd had suicidal ideation in the past two weeks. There was no change in the mean score on the emotional rating scales administered at the beginning and end of the survey.

### Statistical analysis

Proportions are presented as percentages. Odds ratios and Chi-square were used to test for differences at  $p < 0.05$ . Statistical analysis was completed in SPSS. The analysis by region used postcode classified using the Australian Standard Geographical Classification - Remoteness Area (ASGC-RA).(16) Because of small numbers in the very remote, remote and outer regional categories, three categories were used: Major cities; Inner regional; and outer regional/remote. Participants were classified by age groups 18-24 years; 25-34 years; 35-44 years; 45-54 years, and 55 and over. This last category was used because of very small numbers in the 65 years and over age group.

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## RESULTS

### Participant characteristics

299 men completed screening and were eligible to participate. Of these, 251 men completed all or part of the survey (an 84% participation rate). Data reported below is from these 251 men. Participants had a mean age of 36.9 (SD 11.6). One third (34%) were married or in a de facto relationship, 59% were in paid employment, one-quarter (24%) of participants were unemployed or unable to work, and one-quarter (26%) had completed a university degree. The mean PHQ-9 score was 14.4 (SD 10.4) (moderate range), and the mean GAD-7 was 7.0 (SD 5.9) (mild range). Seventy per cent rated their general health as good, very good or excellent, 30% as fair or poor. Fifty per cent were currently receiving treatment for depression, 36% for anxiety, 19% for stress, and 24% were receiving no treatment. Overall, two-thirds of participants were receiving treatment for at least one condition and more than half of the participants (54%) were receiving treatment for two or more conditions. Sixty one per cent had previously received treatment for depression; 47% for anxiety 47%; and 28% for stress. Fifty five per cent endorsed “*thoughts that you would be better off dead or of hurting yourself*” in the past fortnight, as per PHQ-9 item 9.

### Words to describe feeling depressed or suicidal

Men endorsed different words or phrases to describe each state. The most frequently endorsed words or terms to describe when they are feeling suicidal were: *useless or worthless*, *I've had enough*, *hopeless*, *pointless*, and *over it* (Table 1). To describe feeling depressed, the most frequently nominated words or terms were: *stressed*, *tired*, *not going too well*, and *down in the dumps*.

**Table 1: Words men use to describe feeling suicidal or depressed (n=192)**

Words	I use this to describe when I'm feeling suicidal	I use this to describe when I'm feeling depressed
	%	%
Useless or worthless	74	30
I've had enough	69	30
Hopeless	68	27
Pointless	66	25
Over it	62	36

Lost	54	35
Fed up	48	35
Tired	42	52
Not going too well	30	56
Deeply sad	33	30
Stressed	26	56
Angry	22	42
Down in the dumps	9	52

Signs of depression and suicidality

The behaviours that men commonly said others might have noticed when they were feeling down or suicidal were: loss of interest in everything, shutting themselves away, changes in sleep, and poor self-care, followed by being flustered or easily upset, and irritable (Table 2). Fewer men nominated the more overt signs of suicidality such as telling people how they were feeling or saying goodbye to those close to them. Nevertheless, these men constituted a substantial minority of the sample.

Table 2: Signs of depression and suicidality (n= 176)

Signs	%
I lost interest in everything	86
I shut myself away	84
I was sleeping more or less than usual	84
I was not eating well or taking care of myself	83
I was flustered, easily upset	81
I was irritable	79
I was on autopilot	70
I was more aggressive towards others	57

I was taking more risks	52
I was drinking more alcohol	49
I was using more drugs	27
I told one or more people how I was feeling	43
I said goodbye to people	38

Few differences in signs were identified by age, geographic location, or current severity of depression. Those in the 18-24 year age group were more likely to endorse *I was taking more risks* (74% Vs 28% in the 55 years and over age group,  $\chi=12.6$ ,  $p<0.05$ ). There were no other age-related differences in the signs of depression and suicidality. Those living in outer regional or remote areas were more likely to endorse *I was more aggressive towards others* (88% Vs 66% in major cities;  $\chi=8.04$ ,  $p<0.05$ ); whilst those living in inner regional areas were less likely to endorse *I told one or more people how I was feeling* (27% Vs 48% in Major cities and 47% outer regional or remote;  $\chi=6.4$ ,  $p<0.05$ ). Those with PHQ-9 scores in the moderately severe and severe range were more likely to endorse *I said goodbye to people* (49% and 45% respectively, Vs 28% mild and 23% moderate depression,  $\chi=9.2$ ,  $p<0.05$ ).

### Barriers to accessing help

The most frequently nominated barrier to getting help was not wanting to be a burden to others, followed by having distanced one's self from everyone, a tendency to bottle up feelings, and a sense that everything seemed pointless (Table 3). One in six men said that they didn't know where to get help. Only eight per cent of the men surveyed said that there were no barriers to seeking help.

One barrier to accessing help differed by age group, with those aged 18 to 24 years more likely to endorse *I didn't want to burden others* (77% Vs 66%,  $\chi=10.7$ ,  $p<0.05$ ). The only difference in barriers to accessing help by region was *I was worried that I might be hospitalised*, endorsed more strongly by 60% of those in inner regional areas compared with 42% in major cities and 27% in outer regional and remote areas ( $\chi=5.8$ ,  $p<0.05$ ). Those with more severe depression were more likely to endorse *I didn't want to burden others* (72% severe and 88% moderately severe categories Vs 57% mild and 68% moderate categories;  $\chi=11.5$ ,

p<0.05) and *I was worried that I might be hospitalised* (61% severe and 60% moderately severe categories Vs 26% mild and 31% moderate categories;  $\chi^2=13.2$ , p=0.01).

**Table 3: Barriers to accessing help (n= 176)**

Barriers to accessing help	%
I didn't want to burden others	66
I had distanced myself from everyone	63
I just couldn't see the point in getting any help	57
I tend to bottle up my feelings and it's hard for me to talk about it	58
It was my responsibility to handle it	45
Suicide was my go to plan and I wasn't going to let go of that	45
I was worried that I might be hospitalised	45
I had no one around me that I could talk to	43
Society's view of men - this expectation that men are tough and should be able to deal with their own issues	36
The service (e.g. doctor, psychologist, counsellor) I tried wasn't helpful	35
At the time I couldn't see how bad things really were	33
I wanted someone to help but I wouldn't ask for it	32
I didn't want to accept help – that's not me	28
I didn't know where to go for help	17
Nothing - I was able to seek help	8

**What interrupted or stopped a suicide attempt?**

When asked what stopped them from attempting suicide, by far the most strongly endorsed factor was *thinking about the consequences for family* (Table 4). This theme of concern for others was apparent in other strongly endorsed factors: just over half agreed or strongly agreed that *not wanting to put the burden on someone*

*finding them* was a barrier to suicide, followed by half of respondents endorsing *not wanting people to feel it was their fault*. 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 again the most frequently nominated at 32%.

*I didn't want to put the burden on someone finding me* was more likely to be a barrier for those in the 18-24 year age group (66%) and the 45-54 year age group (64%) than in the 25-34 year age group (47%) or the 55 and over age group (28%); ( $\chi = 9.2$ ,  $p < 0.05$ ). *I had a specific commitment to help someone else* was endorsed more by those in the 18-25 year age group (34%) compared with the overall endorsement rate (13%) ( $\chi = 19.9$ ,  $p = 0.001$ ). There were no differences by region. *Being able to talk to someone* was more commonly endorsed by those with no or minimal depression (56%), moderately severe depression (53%), or severe depression (59%) compared with those with mild (28%) or moderate depression scores (37%) ( $\chi = 10.3$ ,  $p < 0.05$ ). *Knowing that I was valued* was endorsed more frequently by those with no depression (56%) or mild depression (48%) compared to those with moderate (31%), moderately severe (29%) or severe depression (27%) ( $\chi = 9.6$ ,  $p < 0.05$ ). Finally, those with severe depression scores were more likely to endorse *I had a specific commitment to help someone else* (25%) compared to those with mild, moderate or moderately severe depression (7%, 6%, and 10% respectively;  $\chi = 9.7$ ,  $p < 0.05$ ).

**Table 4: What interrupts a suicide attempt? (n= 176)**

Interrupting factors	%
I thought about the consequences for my family	67
I didn't want to put the burden on someone finding me	54
I didn't want the people left behind to feel like it was their fault	48
I need to be here for others	38
A friend/family member who was concerned followed up	35
Being able to talk to someone	37
I broke the downward spiral by asking for help	30
Someone gave me some hope	30

I was afraid of dying	27
I really don't want to die	26
My kids wouldn't know me if I died now	25
Knowing that I was valued	23
Good friends spent a lot of time with me	19
I believe it's wrong	13
I had a specific commitment to someone else	13

**What else is needed to interrupt a suicide attempt?**

Men were asked what else is needed to interrupt a suicide attempt (Table 5). A large majority of men (86%) endorsed *I need support from someone I really trust and respect*. 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 this too and that it is normal to struggle sometimes. More than two-thirds want others to notice the changes that they're seeing (e.g. withdrawal, irritability).

There were no differences by age group or region. Those with mild depression or severe depression scores were more likely to endorse *Get me involved in something bigger than myself, like helping others who are worse off* (76% and 61% respectively) compared to those with no depression (36%), moderate depression (49%) or moderately severe depression scores (43%) ( $\chi^2=12.6$ ,  $p<0.05$ ).

Endorsement of *Don't tell me that everything will be okay. Ask me to tell you what's up and then listen with an open mind* was more likely amongst participants with severe depression (91%) or moderate depression (91%) compared to those with mild depression (69%) or moderately severe depression (71%) ( $\chi^2=13.8$ ,  $p<0.01$ ).

**Table 5: What else is needed to interrupt a suicide attempt? (n=150)**

Item	%
I need support from someone I really trust and respect.	86
Don't tell me that everything will be okay. Ask me to tell you what's up and then listen with an open mind.	82
I need to know that others can hear the truth and they won't judge me.	76
Someone needs to notice the changes they're seeing in me, e.g. withdrawal, irritability.	75
We need to let men know that others are going through this too, it's normal to struggle sometimes, and there is help.	74
You need to be very direct and tell me you know what's going on for me. Then support me to get more help.	59
Help me to break my problems down into smaller pieces and then set some goals.	58
Get me involved in something bigger than myself, like helping others who are worse off.	54
Encourage me to do more things for myself, like taking care of myself.	52
Talking to a friend can be easier than family because they're one step removed. There's not so much pressure to get well quickly.	48
Friends and/or family have to get in my face, and stay there because I'm probably not going to ask for help	48

**Best ways to disseminate information to men who are experiencing depression or suicidality**

The following strategies, in order, were endorsed to get information to men: 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 6).

**Table 6: Strategies to disseminate information to men (n= 150)**

Source	Percentage
High profile men in mainstream media	53
Ad campaign directed at men	46
Facebook or other social media	43
Central online source of info	39
Education campaign through GPs	20
Online ads	18
Online chat rooms	11

## DISCUSSION

This study contributes to our understanding of the language men use, the barriers to accessing help, and strategies to interrupt the path to a suicide attempt. With more than half the sample reporting suicidal ideation in the past two weeks, this group of men remain substantially impaired compared to the general population, with 12-month prevalence rates for suicidal ideation of six to eight per cent reported in general population surveys.<sup>(17)</sup> Despite a similar level of educational attainment to that in the wider Australian population, one-quarter of the sample were unemployed or unable to work, an employment rate much higher than the current Australian average of 6.3%.<sup>(18)</sup>

Important to identifying depression and suicidality in men is understanding the language they use to describe it. The language used by men to describe suicidality and depression was varied and subtle. Not surprisingly, men identified different terms to describe depression and suicidality. The terms used to describe suicidality seem indicative of greater despair (*useless or worthless, I've had enough, hopeless, pointless, and over it*) when compared with the language used to describe depression (*stressed, tired, not going too well, and down in the dumps*).

The overt signs of depression and suicidality were the least commonly endorsed. The behaviours that men commonly said others might have noticed when they were feeling down or suicidal were centred on emotional or social withdrawal: changes in sleep, shutting themselves away, loss of interest in everything, and poor self-care. The next most commonly endorsed group of behaviours were signs of emotional disturbance: being flustered or easily upset, and irritable. It is likely that this group of changes would be easily misinterpreted by friends and family. A third group which could be characterised as externalising behaviours - aggression, risk taking, using alcohol and others drugs - were less frequently endorsed. Being more aggressive towards others was more commonly endorsed by those in outer regional or remote areas, and risk taking by younger men, findings worth noting for both clinical and public education purposes. Fewer men nominated the more overt signs of suicidality such as telling people how they were feeling or saying goodbye to those close to them; these signs were nevertheless endorsed by a substantial minority.

The two most commonly endorsed barriers to help seeking – *I didn't want to burden others* and *I had distanced myself from everyone* – are consistent with the Interpersonal-Psychological Theory of suicide, which posits

that perceived burdensomeness and thwarted belongingness are necessary for suicidal thinking.(19, 20) As such, both of these factors seem likely targets for interventions to (1) increase help-seeking and (2) reduce suicidal ideation.

Concern for others (thinking about the consequences for family, not wanting to put the burden on someone finding them, not wanting people to feel it was their fault) was most frequently identified as an interrupting factor and might be considered a psychological factor which can be enhanced. This finding needs to be interpreted within the context of another, that is, that men want others to listen without judgement. Support from trusted and respected people, offered in the right way, was strongly endorsed. So while men might be asked to identify their reasons for living, it is important that men are not made to feel guilty or ‘selfish’ for thinking about suicide.

There were few differences by age; though the youngest age group (18-24 years) showed more differences than any other age group. Similarly, there were few variations across different levels of population density. While there were five differences in total identified by severity of depression, the overall findings were remarkably similar across age groups, region, and severity of depression.

**Limitations**

It is important to note that this was a convenience sample of participants and not a representative sample. These men may differ from other men, who did not see or respond to the survey, in important ways such as their coping strategies and suicidal intent. A potential limitation of the study is that we used current levels of depression when assessing the impact of depression severity on motivations and barriers to seeking help. Severity of depression at the time the man was suicidal may be a better predictor of these factors.

**Implications and conclusions**

The men in this study were able to identify warning signs that they were becoming depressed or suicidal. The signs most commonly endorsed were subtle behavioural changes rather than overt statements of distress. Similarly, most men were able to identify active strategies to interrupt this downward spiral. Men were particularly concerned about the impact that their suicide would have on their family. Importantly,

they were open to being approached by people they trust and respect. Men wanted them to listen without judgement and without offering reassurance that everything would be okay. There were remarkably few differences in these findings by age, region, or depression severity. While the findings of this study need to be confirmed using larger sample sizes, they point to potential intervention targets: education for health professionals and for those who are concerned about a male friend or family member regarding warning signs and the language used by men to describe suicidality; the potential for cognitive intervention regarding perceived burdensomeness as a way to increase help-seeking; behavioural interventions to reduce men's isolation at critical times; and interventions for family and friends regarding how to approach men about whom they're concerned. Finally, while there were no overwhelmingly endorsed strategies for disseminating information to men, the most strongly endorsed strategies focussed on a male-specific campaign with high profile men talking in the mainstream media about their experience of depression and suicidality, suggesting that stigma reduction campaigns continue to be important.

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# BMJ Open

## What might interrupt men's suicide? Results from an online survey of men

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Title: What might interrupt men’s suicide? Results from an online survey of men

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## ABSTRACT

**Objectives:** Men are almost two times more likely to die by suicide than women, yet little research has focussed on what is required to prevent suicide amongst men. This paper aims to investigate what factors interrupt suicidal behaviour in men, and to examine differences according to known suicide risk factors.

**Setting:** Australia

**Participants:** 251 Australian men aged 18 and over who had made a suicide attempt 6-18 months prior to completing the survey.

**Outcomes:** The survey canvassed the language men use to describe their depression and suicidality, warning signs, barriers to accessing help, and what is needed to interrupt a suicide attempt. Odds ratios and Chi-square were used to test for differences by age, geographic location, and current depression severity.

**Results:** Of 299 men screened and eligible to participate, 251 completed all or part of the survey. Participants identified different words and warnings signs for depression compared with suicidality. The most commonly endorsed barriers to accessing help were not wanting to burden others (66%) and having isolated themselves (63%). Men overwhelmingly endorsed 'I thought about the consequences for my family' as the factor which stopped a suicide attempt (67%). 'I need support from someone I really trust and respect' was also strongly endorsed. There were few differences by age, region or depression severity.

**Conclusions:** Participants were able to identify signs, albeit often subtle ones, that they were becoming depressed or suicidal. Similarly, most were able to identify active strategies to interrupt this downward spiral. Men wanted others to notice changes in their behaviour, and to approach them without judgement.

### Strengths and limitations of this study

- This was a mixed methods study with substantial input from people with lived experience into the quantitative survey.
- This was a convenience sample of participants and not a representative sample.
- These men may differ from other men, who did not see or respond to the survey, in important ways such as their coping strategies and suicidal intent.

INTRODUCTION

Around seventy-five per cent of suicide deaths in Australia are men. Suicide is the leading cause of death among Australian men aged 18 to 44 (1), and is particularly prevalent amongst men who are separated or divorced, unemployed, experiencing ill health, chronic pain, mental illness and substance use disorders.(2, 3) Globally, men are almost two times more likely to die by suicide than women, with inter-country ratios ranging from 0.9 to 4.1.(3) In Australia, men in regional and rural areas are particularly at risk.(4)

Although men have lower reported rates of mood and anxiety disorders, suicidal ideation and suicide attempts than women, they have higher rates of risk taking, impulsivity, and substance use disorders.(5) These are factors which put them at risk of progressing from suicidal thinking to a suicide attempt.(6)

Further gender differences are evident in help-seeking and coping strategies. Men seek help for depression and suicidality less often.(7) Of the men who reported a 12-month mental disorder in 2007, only 27 per cent sought professional assistance, compared with 41 per cent of women.(8) Suicidal males have a higher threshold for help seeking than women.(7) In the 12 months prior to suicide, fewer men than women sought help from a mental health professional or primary care providers.(9) Young women also have greater social support and are more likely to use it than young men, in addition to being more likely to ‘vent’ or turn to religion.(10) With increased isolation a risk factor for suicidality, seeking social support is likely to be an effective protective behaviour for women. One further difference likely to have a substantial impact on the gender difference in suicide deaths is men’s choice of more lethal means, which goes some way to explaining why women have more suicide attempts but fewer deaths.(11)

Despite the scope of the problem for men, little is known about how to prevent men’s suicidal behaviours or how to interrupt a man’s suicide attempt. Even less research has examined this issue from the perspective of those with lived experience.(12) The current study aims to address this gap. Specifically, it aims to:

- 1) Investigate what factors interrupt suicidal behaviour and contribute to taking action during a suicidal crisis.
- 2) Examine differences according to known risk factors for death by suicide: regional or remote geographic location, older age, and higher depression severity.

## METHOD

### Design

As part of a mixed method study investigating men's experiences of depression and suicidality, two online surveys were conducted with (a) men who had made a suicide attempt in the previous six to 18 months; and (b) family or friends of men who had made a suicide attempt between six and 18 months prior to survey participation. Data reported here are from the men's survey only. The survey items were derived from themes emerging from phase one of the study, a qualitative project, where men took part in interviews and family and friends took part in focus groups examining what factors contribute to suicidal behaviour and depression and what interrupts suicidal behaviour.<sup>(13)</sup> The wording used for the questions and responses came from the language used by the men during their interviews.

### Participants

Participants were screened online and were required to be male, aged 18 or over, living in Australia, and to have had a suicide attempt in the past six to 18 months. This timeframe was chosen to ensure accurate recall on the one hand, and to minimise the risk that participants remained actively suicidal and vulnerable on the other. Participants were recruited through a national publicity campaign. The project was publicised nationally through our partner organisations beyondblue, Faces in the Street, and Mensheds Australia, and through the Black Dog Institute's website and social media channels (Facebook and Twitter), Lifeline, state and territory consumer and carer networks, mental health professional networks, and suicide prevention organisations. Ethics approval for the research was provided by the UNSW Human Research Ethics Committee (HREC 13077).

### Survey instrument and measures

The survey collected data on demographics (age; postcode; marital status, employment status, Aboriginal/Torres Strait Islander status, self-reported general health, and educational attainment: see online supplementary file). The presence and severity of depression was assessed using the Patient Health Questionnaire-9 (PHQ-9). The PHQ-9 is a nine item self-administered scale which assesses how often in the past two weeks participants have been bothered by a range of symptoms or problems.<sup>(14)</sup> Current

level of depression used the standardised PHQ-9 categories whereby 1-4 is minimal depression, 5-9 is mild, 10-14 is moderate, 15-19 moderately severe, and 20-28 severe. Anxiety was assessed using the Generalized Anxiety Disorder-7 (GAD-7) Scale. The GAD-7 is a seven item self-administered scale used to assess the severity of generalised anxiety by asking how often participants have experienced symptoms in the previous two weeks (15). Both scales have good reliability and validity.(14, 15) Current level of anxiety used the standardised GAD-7 categories where 0-4 is no or minimal anxiety, 5-9 is mild, 10-14 is moderate, and 15-21 severe. Participants were also asked if they were currently receiving treatment and/or had ever received treatment for depression, anxiety or stress.

For the online survey, the response categories for each question described below were drawn from the phase one interviews and focus groups. All questions allowed for an ‘other’ response followed by free text. Participants were asked to select a response to each of the following questions:

1. What words do you use to describe when you are feeling (a) down in the dumps; and (b) that life isn’t worth living? (select all that apply).
2. What changes would people have seen when you were feeling really down and that life was not worth living? (the response scale was ‘strongly agree’ to ‘strongly disagree’ with ‘strongly agree’ and ‘agree’ dichotomised into ‘agree’ and all other responses coded as ‘disagree’).
3. When you were feeling down in the dumps, what got in the way of you seeking help? (select all that apply).
4. When you've felt that life was not worth living, what was it that stopped you from making a suicide attempt? (the response scale was ‘strongly agree’ to ‘strongly disagree’ with ‘strongly agree’ and ‘agree’ dichotomised into ‘agree’ and all other responses coded as ‘disagree’).
5. What else is needed to interrupt a suicide attempt? (the response scale was 1-5 with 5 being extremely important and 1 being not at all important, with 1 to 3 coded as unimportant and 4 to 5 as important).
6. In your opinion, what is the best way to get information and strategies to men and their family and friends? (select one or more options)

The survey was initially tested for length and clarity with a small number of participants. It was then modified and re-tested using the *Think Aloud Method*, which is designed to identify participants thought processes while they complete the survey. (16) Participants are asked to complete the survey and as they do so, to verbalise their thoughts, with a researcher listening to them 'thinking aloud' without being directly addressed by the participant. The researcher also observes the participant's non-verbal behaviours (sighing, pauses, slouching, taking a long time on a question, having to read a question more than once). This feedback was used to modify the survey before its release. The final survey was built and administered online using QuestionPro.(17)

### Participant safety

Screening excluded those who had made a suicide attempt in the past six months. People who were ineligible as well as any participants who were distressed could enter their contact details in order to be contacted directly by Lifeline, who were contracted to provide special follow up services for the study. Participants were asked at the beginning and end of the survey to rate their level of sadness, irritability, anxiety and agitation on a zero to 10 scale. A rating of 8 or more triggered a webpage expressing concern about their level of distress and where participants could enter their contact details to receive contact from Lifeline. The same page was triggered if participants scored in the severe range on the PHQ-9 or GAD-7, or indicated on PHQ-9 question 9 that they'd had suicidal ideation in the past two weeks. There was no change in the mean score on the emotional rating scales administered at the beginning and end of the survey.

### Statistical analysis

Proportions are presented as percentages. Odds ratios and Chi-square were used to test for differences at  $p < 0.05$ . Statistical analysis was completed in SPSS. The analysis by region used postcode classified using the Australian Standard Geographical Classification - Remoteness Area (ASGC-RA).(18) Because of small numbers in the very remote, remote and outer regional categories, three categories were used: Major cities; Inner regional; and outer regional/remote. Participants were classified by age groups 18-24 years; 25-34 years; 35-44 years; 45-54 years, and 55 and over. This last category was used because of very small numbers in the 65 years and over age group.

RESULTS

Participant characteristics

299 men completed screening and were eligible to participate. Of these, 251 men completed all or part of the survey (an 84% participation rate). Data reported below is from these 251 men. Participants had a mean age of 36.9 (SD 11.6). One third (34%) were married or in a de facto relationship, 59% were in paid employment, one-quarter (24%) of participants were unemployed or unable to work, and one-quarter (26%) had completed a university degree. The mean PHQ-9 score was 14.4 (SD 10.4) (moderate range), and the mean GAD-7 was 7.0 (SD 5.9) (mild range). Seventy per cent rated their general health as good, very good or excellent, 30% as fair or poor. Fifty per cent were currently receiving treatment for depression, 36% for anxiety, 19% for stress, and 24% were receiving no treatment. Overall, two-thirds of participants were receiving treatment for at least one condition and more than half of the participants (54%) were receiving treatment for two or more conditions. Sixty one per cent had previously received treatment for depression; 47% for anxiety 47%; and 28% for stress. Fifty five per cent endorsed “*thoughts that you would be better off dead or of hurting yourself*” in the past fortnight, as per PHQ-9 item 9.

Words to describe feeling depressed or suicidal

Men endorsed different words or phrases to describe each state. The most frequently endorsed words or terms to describe when they are feeling suicidal were: *useless or worthless, I’ve had enough, hopeless, pointless, and over it* (Table 1). To describe feeling depressed, the most frequently nominated words or terms were: *stressed, tired, not going too well, and down in the dumps*.

**Table 1: Words men use to describe feeling suicidal or depressed (n=192)**

Words	I use this to describe when I’m feeling suicidal %	I use this to describe when I’m feeling depressed %
Useless or worthless	74	30
I’ve had enough	69	30
Hopeless	68	27
Pointless	66	25
Over it	62	36

Lost	54	35
Fed up	48	35
Tired	42	52
Not going too well	30	56
Deeply sad	33	30
Stressed	26	56
Angry	22	42
Down in the dumps	9	52

### Signs of depression and suicidality

The behaviours that men commonly said others might have noticed when they were feeling down or suicidal were: loss of interest in everything, shutting themselves away, changes in sleep, and poor self-care, followed by being flustered or easily upset, and irritable (Table 2). Fewer men nominated the more overt signs of suicidality such as telling people how they were feeling or saying goodbye to those close to them. Nevertheless, these men constituted a substantial minority of the sample.

**Table 2: Signs of depression and suicidality (n= 176)**

Signs	%
I lost interest in everything	86
I shut myself away	84
I was sleeping more or less than usual	84
I was not eating well or taking care of myself	83
I was flustered, easily upset	81
I was irritable	79
I was on autopilot	70
I was more aggressive towards others	57

I was taking more risks	52
I was drinking more alcohol	49
I was using more drugs	27
I told one or more people how I was feeling	43
I said goodbye to people	38

Few differences in signs were identified by age, geographic location, or current severity of depression. Those in the 18-24 year age group were more likely to endorse *I was taking more risks* (74% Vs 28% in the 55 years and over age group,  $\chi=12.6$ ,  $p<0.05$ ). There were no other age-related differences in the signs of depression and suicidality. Those living in outer regional or remote areas were more likely to endorse *I was more aggressive towards others* (88% Vs 66% in major cities;  $\chi=8.04$ ,  $p<0.05$ ); whilst those living in inner regional areas were less likely to endorse *I told one or more people how I was feeling* (27% Vs 48% in Major cities and 47% outer regional or remote;  $\chi=6.4$ ,  $p<0.05$ ). Those with PHQ-9 scores in the moderately severe and severe range were more likely to endorse *I said goodbye to people* (49% and 45% respectively, Vs 28% mild and 23% moderate depression,  $\chi=9.2$ ,  $p<0.05$ ).

Barriers to accessing help

The most frequently nominated barrier to getting help was not wanting to be a burden to others, followed by having distanced one’s self from everyone, a tendency to bottle up feelings, and a sense that everything seemed pointless (Table 3). One in six men said that they didn’t know where to get help. Only eight per cent of the men surveyed said that there were no barriers to seeking help.

One barrier to accessing help differed by age group, with those aged 18 to 24 years more likely to endorse *I didn’t want to burden others* (77% Vs 66%,  $\chi=10.7$ ,  $p<0.05$ ). The only difference in barriers to accessing help by region was *I was worried that I might be hospitalised*, endorsed more strongly by 60% of those in inner regional areas compared with 42% in major cities and 27% in outer regional and remote areas ( $\chi=5.8$ ,  $p<0.05$ ). Those with more severe depression were more likely to endorse *I didn’t want to burden others* (72% severe and 88% moderately severe categories Vs 57% mild and 68% moderate categories;  $\chi=11.5$ ,

$p < 0.05$ ) and *I was worried that I might be hospitalised* (61% severe and 60% moderately severe categories Vs 26% mild and 31% moderate categories;  $\chi^2 = 13.2$ ,  $p = 0.01$ ).

**Table 3: Barriers to accessing help (n= 176)**

Barriers to accessing help	%
I didn't want to burden others	66
I had distanced myself from everyone	63
I just couldn't see the point in getting any help	57
I tend to bottle up my feelings and it's hard for me to talk about it	58
It was my responsibility to handle it	45
Suicide was my go to plan and I wasn't going to let go of that	45
I was worried that I might be hospitalised	45
I had no one around me that I could talk to	43
Society's view of men - this expectation that men are tough and should be able to deal with their own issues	36
The service (e.g. doctor, psychologist, counsellor) I tried wasn't helpful	35
At the time I couldn't see how bad things really were	33
I wanted someone to help but I wouldn't ask for it	32
I didn't want to accept help – that's not me	28
I didn't know where to go for help	17
Nothing - I was able to seek help	8

#### What interrupted or stopped a suicide attempt?

When asked what stopped them from attempting suicide, by far the most strongly endorsed factor was *thinking about the consequences for family* (Table 4). This theme of concern for others was apparent in other strongly endorsed factors: just over half agreed or strongly agreed that *not wanting to put the burden on someone*

*finding them* was a barrier to suicide, followed by half of respondents endorsing *not wanting people to feel it was their fault*. 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 again the most frequently nominated at 32%.

*I didn't want to put the burden on someone finding me* was more likely to be a barrier for those in the 18-24 year age group (66%) and the 45-54 year age group (64%) than in the 25-34 year age group (47%) or the 55 and over age group (28%); ( $\chi = 9.2, p<0.05$ ). *I had a specific commitment to help someone else* was endorsed more by those in the 18-25 year age group (34%) compared with the overall endorsement rate (13%) ( $\chi =19.9, p=0.001$ ). There were no differences by region. *Being able to talk to someone* was more commonly endorsed by those with no or minimal depression (56%), moderately severe depression (53%), or severe depression (59%) compared with those with mild (28%) or moderate depression scores (37%) ( $\chi =10.3, p<0.05$ ). *Knowing that I was valued* was endorsed more frequently by those with no depression (56%) or mild depression (48%) compared to those with moderate (31%), moderately severe (29%) or severe depression (27%) ( $\chi=9.6, p<0.05$ ). Finally, those with severe depression scores were more likely to endorse *I had a specific commitment to help someone else* (25%) compared to those with mild, moderate or moderately severe depression (7%, 6%, and 10% respectively;  $\chi =9.7, p<0.05$ ).

**Table 4: What interrupts a suicide attempt? (n= 176)**

Interrupting factors	%
I thought about the consequences for my family	67
I didn't want to put the burden on someone finding me	54
I didn't want the people left behind to feel like it was their fault	48
I need to be here for others	38
A friend/family member who was concerned followed up	35
Being able to talk to someone	37
I broke the downward spiral by asking for help	30
Someone gave me some hope	30

I was afraid of dying	27
I really don't want to die	26
My kids wouldn't know me if I died now	25
Knowing that I was valued	23
Good friends spent a lot of time with me	19
I believe it's wrong	13
I had a specific commitment to someone else	13

### What else is needed to interrupt a suicide attempt?

Men were asked what else is needed to interrupt a suicide attempt (Table 5). A large majority of men (86%) endorsed *I need support from someone I really trust and respect*. 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 this too and that it is normal to struggle sometimes. More than two-thirds want others to notice the changes that they're seeing (e.g. withdrawal, irritability).

There were no differences by age group or region. Those with mild depression or severe depression scores were more likely to endorse *Get me involved in something bigger than myself, like helping others who are worse off* (76% and 61% respectively) compared to those with no depression (36%), moderate depression (49%) or moderately severe depression scores (43%) ( $\chi^2=12.6$ ,  $p<0.05$ ).

Endorsement of *Don't tell me that everything will be okay. Ask me to tell you what's up and then listen with an open mind* was more likely amongst participants with severe depression (91%) or moderate depression (91%) compared to those with mild depression (69%) or moderately severe depression (71%) ( $\chi^2=13.8$ ,  $p<0.01$ ).

**Table 5: What else is needed to interrupt a suicide attempt? (n=150)**

Item	%
I need support from someone I really trust and respect.	86
Don't tell me that everything will be okay. Ask me to tell you what's up and then listen with an open mind.	82
I need to know that others can hear the truth and they won't judge me.	76
Someone needs to notice the changes they're seeing in me, e.g. withdrawal, irritability.	75
We need to let men know that others are going through this too, it's normal to struggle sometimes, and there is help.	74
You need to be very direct and tell me you know what's going on for me. Then support me to get more help.	59
Help me to break my problems down into smaller pieces and then set some goals.	58
Get me involved in something bigger than myself, like helping others who are worse off.	54
Encourage me to do more things for myself, like taking care of myself.	52
Talking to a friend can be easier than family because they're one step removed. There's not so much pressure to get well quickly.	48
Friends and/or family have to get in my face, and stay there because I'm probably not going to ask for help	48

### Best ways to disseminate information to men who are experiencing depression or suicidality

The following strategies, in order, were endorsed to get information to men: 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 6).

**Table 6: Strategies to disseminate information to men (n= 150)**

Source	Percentage
High profile men in mainstream media	53
Ad campaign directed at men	46
Facebook or other social media	43
Central online source of info	39
Education campaign through GPs	20
Online ads	18
Online chat rooms	11

DISCUSSION

This study contributes to our understanding of the language men use, the barriers to accessing help, and strategies to interrupt the path to a suicide attempt. With more than half the sample reporting suicidal ideation in the past two weeks, this group of men remain substantially impaired compared to the general population, with 12-month prevalence rates for suicidal ideation of six to eight per cent reported in general population surveys.<sup>(19)</sup> Despite a similar level of educational attainment to that in the wider Australian population, one-quarter of the sample were unemployed or unable to work, an employment rate much higher than the current Australian average of 6.3%.<sup>(20)</sup>

Important to identifying depression and suicidality in men is understanding the language they use to describe it. The words endorsed by men to describe suicidality were different to those used to describe depression. The terms used to describe suicidality seem indicative of greater despair (*useless or worthless, I've had enough, hopeless, pointless, and over it*) when compared with the language used to describe depression (*stressed, tired, not going too well, and down in the dumps*).

The overt signs of depression and suicidality were the least commonly endorsed. The behaviours that men commonly said others might have noticed when they were feeling down or suicidal were centred on emotional or social withdrawal: changes in sleep, shutting themselves away, loss of interest in everything, and poor self-care. The next most commonly endorsed group of behaviours were signs of emotional disturbance: being flustered or easily upset, and irritable. It is likely that this group of changes would be easily misinterpreted by friends and family. A third group which could be characterised as externalising behaviours - aggression, risk taking, using alcohol and others drugs - were less frequently endorsed. Being more aggressive towards others was more commonly endorsed by those in outer regional or remote areas, and risk taking by younger men, findings worth noting for both clinical and public education purposes. Fewer men nominated the more overt signs of suicidality such as telling people how they were feeling or saying goodbye to those close to them; these signs were nevertheless endorsed by a substantial minority.

The two most commonly endorsed barriers to help seeking – *I didn't want to burden others* and *I had distanced myself from everyone* – are consistent with the Interpersonal-Psychological Theory of suicide, which posits that perceived burdensomeness and thwarted belongingness are necessary for suicidal thinking.<sup>(21, 22)</sup> As

such, both of these factors seem likely targets for interventions to (1) increase help-seeking and (2) reduce suicidal ideation.

Concern for others (thinking about the consequences for family, not wanting to put the burden on someone finding them, not wanting people to feel it was their fault) was most frequently identified as an interrupting factor and might be considered a psychological factor which can be enhanced. This finding needs to be interpreted within the context of another, that is, that men want others to listen without judgement. Support from trusted and respected people, offered in the right way, was strongly endorsed. So while men might be asked to identify their reasons for living, it is important that men are not made to feel guilty or 'selfish' for thinking about suicide.

There were few differences by age; though the youngest age group (18-24 years) showed more differences than any other age group. Similarly, there were few variations across different levels of population density. There were several differences identified by severity of depression, some of which appeared to centre around a tendency to focus on others' needs among those participants with more severe depression: 'Get me involved in something bigger than myself, like helping others who are worse off' and 'having a specific commitment to helping someone else' as factors which interrupt an attempt; and not wanting to burden others as a barrier to accessing help. These findings would benefit from further exploration. Nevertheless, the overall findings were remarkably similar across age groups, region, and severity of depression.

### Limitations

It is important to note that this was a convenience sample of participants and not a representative sample. These men may differ from other men, who did not see or respond to the survey, in important ways such as their coping strategies and suicidal intent. For instance, two thirds of our participants were receiving treatment for depression, anxiety or stress, compared with 27% of men with a mental health disorder in the general population.<sup>(23)</sup> A potential limitation of the study is that we used current levels of depression when assessing the impact of depression severity on motivations and barriers to seeking help. Severity of depression at the time the man was suicidal may be a better predictor of these factors. It is also possible

that participants' retrospective thinking about their suicide attempt may be influenced by their current levels of depression.

**Implications and conclusions**

The men in this study were able to identify warning signs that they were becoming depressed or suicidal. The signs most commonly endorsed were subtle behavioural changes rather than overt statements of distress. Similarly, most men were able to identify active strategies to interrupt this downward spiral. Men were particularly concerned about the impact that their suicide would have on their family. Importantly, they were open to being approached by people they trust and respect. Men wanted them to listen without judgement and without offering reassurance that everything would be okay. There were remarkably few differences in these findings by age, region, or depression severity. While the findings of this study need to be confirmed using larger sample sizes, they point to potential intervention targets: education for health professionals and for those who are concerned about a male friend or family member regarding warning signs and the language used by men to describe suicidality; the potential for cognitive intervention regarding perceived burdensomeness as a way to increase help-seeking; behavioural interventions to reduce men's isolation at critical times; and interventions for family and friends regarding how to approach men about whom they're concerned. Finally, while there were no overwhelmingly endorsed strategies for disseminating information to men, the most strongly endorsed strategies focussed on a male-specific campaign with high profile men talking in the mainstream media about their experience of depression and suicidality, suggesting that stigma reduction campaigns continue to be important.

**Contributorship statement**

FS led the design of the online survey, drafted the manuscript and led the data analysis. JP, AF, KW, DHP and HC contributed to the design of the larger project and MS to the qualitative component. MJP, AF, EW and IT assisted with the design, programming and piloting of the online survey. DHP advised on data analysis. All authors contributed to revising drafts of the manuscript.

**Competing interests**

No, there are no competing interests.

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**Data sharing statement**

No additional data available.

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## Men's Experiences Survey

You are invited to take part in a survey to find out what may prevent suicidal behaviours in men. This information will help us develop new strategies that can then be used by other men in the community to help them to avert or respond more constructively to life's difficulties. If you are a man who has made a suicide attempt, this survey may be suitable for you. This project is being conducted by the Black Dog Institute, University of New South Wales, in partnership with Faces in the Street, St Vincents Hospital and Mensheds Australia. The first few questions are to let you know if this survey is suitable for you.

Do you live in Australia?

1. Yes
2. No

Are you able to read and write in English?

1. Yes
2. No

Are you 18 years or older?

1. Yes
2. No

Are you male?

1. Yes
2. No

We're looking for men who have made a suicide attempt between 6 and 18 months ago. Is this the case for you?

1. Yes
2. No

**Thank you. It seems this survey is suitable for you. If you'd like to continue, we need you to read some information and consent to taking part.**

HREC Approval No 13077 THE UNIVERSITY OF NEW SOUTH WALES AND BLACK DOG INSTITUTE PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM "What helps prevent suicidal behaviours in men" Research partners: This project is being conducted by the Black Dog Institute, University of New South Wales, in partnership with Faces in the Street, St Vincents Hospital and Mensheds Australia. Purpose of the project: You are invited to take part in a project to find out what may prevent suicidal behaviours in men. We want to understand the factors associated with the interruption, and prevention of suicidal behaviours. This information will help us develop new strategies that can then be used by other men in the community to help them to avert or respond more constructively to life's difficulties. You were selected as a possible participant in this study because you are a male or a friend or family member of a male who has who has had a suicide attempt, and you have volunteered through Mensheds Australia or responded to our advertisement/email invitation. Description of the project and risks: If you decide to participate, we will ask you to share your own experience of depression, suicidal thoughts and behaviours, as well as the strategies that you have used in the past to cope with these experiences as well as health, mood and lifestyle in an online survey. There are no known risks that are likely to arise as a result of taking part in this study, except that speaking about difficult feelings may cause you to experience some temporary distress. However, we do not think it will cause you any lasting discomfort or inconvenience. Participation is voluntary and you are welcome to pause or stop taking part at any stage. Stopping will not incur any penalty and your decision will not affect your relationship with the University of New South Wales, the Black Dog Institute, Mensheds Australia or Faces in the Street. Please note that we cannot and do not guarantee or promise that you will receive any benefits from this study, but we have found that men report positive experiences of participating in our research. Confidentiality and disclosure of information: Participation in the survey is

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anonymous and confidential. By consenting to participate, you give us your permission to publish the results in a scientific journal. We will also disseminate them in reports written in lay terms to men's organisations. However, depending on your answers, you may be offered assistance to connect with services. If you accept this offer, you will be asked to provide your contact details and will no longer be anonymous. Any information obtained in connection with this study will remain confidential and will only be disclosed with your permission, except as required by law. Reports about the project will be written in such a way that no one can be identified. Complaints may be directed to the Ethics Secretariat, The University of New South Wales, SYDNEY 2052 AUSTRALIA (phone 9385 4234, fax 9385 6648, email [ethics.sec@unsw.edu.au](mailto:ethics.sec@unsw.edu.au)). Any complaint you make will be investigated promptly and you will be informed of the outcome. Your consent: Your decision whether or not to participate will not prejudice your future relations with the University of New South Wales, the Black Dog Institute, Mensheds Australia or Faces in the Street. If you decide to participate, you are free to stop participating at any time without prejudice. If you have any questions about the study later, Associate Professor Judy Proudfoot, (02) 9382 3767 will be happy to answer them.

1. I consent

**Through your participation in this survey, we hope to be able to help other men who are suffering and unsure how to get help. So let's start with more about you.**

What is your post code?

Are you:

- 1. Employed full-time
- 2. Employed part-time
- 3. Retired
- 4. Self-employed
- 5. Full-time home duties
- 6. Temporarily unable to work because of illness or injury
- 7. Permanently unable to work because of illness or injury
- 8. Able to work but unemployed
- 9. Full-time student
- 10. Other

What is your current marital status?

- 1. Never married
- 2. Married
- 3. De facto
- 4. Separated but not divorced
- 5. Divorced
- 6. Widowed

Which of these best describes the highest level of education you have completed?

- 1. Primary school
- 2. Secondary school
- 3. Trade or technician certificate or apprenticeship
- 4. Other certificate or diploma
- 5. University or college Bachelor Degree
- 6. University or college Postgraduate degree

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Are you of Aboriginal and/or Torres Strait Islander origin?

1. No
2. Yes, Aboriginal
3. Yes, Torres Strait Islander
4. Yes, both Aboriginal and Torres Strait Islander

What is your age?

In general, how would you rate your health?

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor

We'd like to know how you're feeling right now.

For each item below, please provide a rating from 0 (not at all) to 10 (extremely):

	0	1	2	3	4	5	6	7	8	9	10
How sad are you feeling right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How irritable are you feeling right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How agitated are you feeling right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How anxious are you feeling right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Triggered if high levels of distress are endorsed) We're concerned you are having a tough time now and we do recommend that you get some help. Would you like to be contacted by Lifeline? We have an arrangement with Lifeline for this research project to provide help if people would like it. If you enter your contact details in the box, we (the research team) won't know what you talked about with Lifeline. Any contact you have with Lifeline will remain confidential. At the end of the project, Lifeline will just report to us on how many people they contacted during the study but will not give any details about individuals. Yes, I would like to be contacted by Lifeline in the next 24hrs. Please click here to submit your phone number. Otherwise, please click Continue to resume the survey.

The next few questions are to help us understand what it's like for men when they're feeling down, and how to help men who might be thinking about suicide without knowing that there is good help available. Your answers will help us to come up with strategies to help men who are suffering in silence. You've told us that you've been through a tough time and we'd like to share what you've learned with other men. We'd like to ask you about the last time you were feeling really down and that life wasn't worth living.

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What words do you use to describe when you're really down or that life isn't worth living? (Select all that apply)

	I use this to describe when I'm feeling life isn't worth living	I use this to describe when I'm feeling really down in the dumps
1. Not going too well	<input type="checkbox"/>	<input type="checkbox"/>
2. Deeply sad	<input type="checkbox"/>	<input type="checkbox"/>
3. Lost	<input type="checkbox"/>	<input type="checkbox"/>
4. Down in the dumps	<input type="checkbox"/>	<input type="checkbox"/>
5. Angry	<input type="checkbox"/>	<input type="checkbox"/>
6. Useless, worthless	<input type="checkbox"/>	<input type="checkbox"/>
7. Stressed	<input type="checkbox"/>	<input type="checkbox"/>
8. Fed up	<input type="checkbox"/>	<input type="checkbox"/>
9. Tired	<input type="checkbox"/>	<input type="checkbox"/>
10. Over it	<input type="checkbox"/>	<input type="checkbox"/>
11. Ive had enough	<input type="checkbox"/>	<input type="checkbox"/>
12. Pointless	<input type="checkbox"/>	<input type="checkbox"/>
13. Hopeless	<input type="checkbox"/>	<input type="checkbox"/>

Are there any other words we haven't mentioned that you use to describe when you're feeling really down?

Are there any other words we haven't mentioned that you use to describe when you're feeling that life isn't worth living?

What changes would people have seen when you were feeling really down and that life was not worth living?

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	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. I lost interest in pretty much everything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I was taking more risks e.g. driving faster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I was more aggressive towards others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was not eating well or taking care of myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I shut myself away - didn't answer my phone or email, didn't answer the door	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I was sleeping more or less than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I was on autopilot (doing things without thinking about it)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I was flustered, easily upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was irritable, particularly with my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I was drinking more alcohol than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I was using more drugs than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I told one or more people how I was feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I said goodbye to the important people in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Were there any other changes that people would have seen that we missed?

When you were feeling down in the dumps, what got in the way of you seeking help? (Select all that apply)

1. Nothing - I was able to seek help
2. Society's view of men - this expectation that men are tough and should be able to deal with their own issues.
3. I didn't want to burden other people with my stuff.
4. I didn't want to accept help - that's not me.
5. I tend to bottle up my feelings and it's hard for me to talk about it.
6. I had no one around me that I could talk to.
7. I had distanced myself from everyone.
8. It was my responsibility to handle it.
9. I wanted someone to help but I wouldn't ask for it.
10. Suicide was my go to plan and I wasn't going to let go of that.
11. I didn't know where to go for help.
12. I was worried that if I spoke to someone I might be hospitalised.
13. At the time I couldn't see how bad things really were.
14. I just couldn't see the point in getting any help. Everything seemed pointless.

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15. The service (e.g. doctor, psychologist, counsellor) I tried wasn't helpful

16. Other (please describe)

When you've felt that life was not worth living, what was it that stopped you from making a suicide attempt?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. I thought about the consequences for my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I didn't want to put the burden on someone finding me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I need to be here for others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Someone gave me some hope.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My kids wouldn't know me if I died now.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I didn't want the people I left behind to feel like it was their fault.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Good friends spent a lot of time with me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I really don't want to die.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I believe its wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I broke the downward spiral by asking for help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I was afraid of dying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Being able to talk to someone helped me think more clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. A friend or family member who was concerned and followed up with real support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Knowing that I was valued, especially by friends who didn't have to say that they value me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I had a specific commitment to help someone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which of the above would you consider the most important? (Please choose the corresponding number)

- 1. 1
- 2. 2
- 3. 3
- 4. 4
- 5. 5
- 6. 6
- 7. 7
- 8. 8

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9. 9
10. 10
11. 11
12. 12
13. 13
14. 14
15. 15

Is there anything else we haven't mentioned that has stopped you from making an attempt in the past?

What else is needed to interrupt a suicide attempt? Please rate how important you think each of the following factors are:

	1 (extremely important)	2	3	4	5 (not important at all)
1. Talking to a friend can be easier than family because they're one step removed. There's not so much pressure to get well quickly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Someone needs to notice the changes they're seeing in me, e.g. withdrawal, irritability.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Friends and/or family have to get in my face, and stay there because I'm probably not going to ask for help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. You need to be very direct and tell me you know what's going on for me. Then support me to get more help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I need support from someone I really trust and respect.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I need to know that others can hear the truth and they won't judge me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. We need to let men know that others are going through this too, it's normal to struggle sometimes, and there is help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Get me involved in something bigger than myself, like helping others who are worse off.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Don't tell me that everything will be okay. Ask me to tell you what's up and then listen with an open mind.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Help me to break my problems down into smaller pieces and then set some goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Encourage me to do more things for myself, like taking care of myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything else you can think of that is needed to interrupt an attempt and hasn't been mentioned?

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Thanks for staying with us so far. Next are a few questions about how you've been feeling in recent weeks.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading a newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people could have noticed - or being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Triggered if threshold score is reached or item 9 endorsed) Were concerned you are having a tough time now and we do recommend that you get some help. Would you like to be contacted by Lifeline? We have an arrangement with Lifeline for this research project to provide help if people would like it. If you enter your contact details in the box, we (the research team) won't know what you talked about with Lifeline. Any contact you have with Lifeline will remain confidential. At the end of the project, Lifeline will just report to us on how many people they contacted during the study but will not give any details about individuals. Yes, I would like to be contacted by Lifeline in the next 24hrs. Please click here to submit your phone number. Otherwise, please click Continue to resume the survey.

- How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- 1. Not difficult at all
  - 2. Somewhat difficult
  - 3. Very difficult
  - 4. Extremely difficult

Outside of the past 2 weeks, have you ever had a period where you felt down, had difficulty in cheering up, lost pleasure in things,

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and/or not been able to cope as well as usual for a period of at least 2 weeks?

1. Yes, in the past month
2. Yes, in the past 12 months
3. Yes, but it was more than 12 months ago
4. No, never

How old were you the first time this happened?

1. 0-12 yrs
2. 13-19 yrs
3. 20-29 yrs
4. 30-39 yrs
5. 40 yrs or more
6. Don't know

How many times have you felt this way?

1. 1-3 times
2. 4-9 times
3. 10 or more times
4. Don't know

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Triggered if threshold score is reached) Were concerned you are having a tough time now and we do recommend that you get some help. Would you like to be contacted by Lifeline? We have an arrangement with Lifeline for this research project to provide help if people would like it. If you enter your contact details in the box, we (the research team) won't know what you talked about with Lifeline. Any contact you have with Lifeline will remain confidential. At the end of the project, Lifeline will just report to us on how many people they contacted during the study but will not give any details about individuals. Yes, I would like to be contacted by Lifeline in the next 24hrs. Please click here to submit your phone number. Otherwise, please click Continue to resume the survey.

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

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- 1. Not difficult at all
- 2. Somewhat difficult
- 3. Very difficult
- 4. Extremely difficult

Not including the past two weeks, have you EVER had a period where you have felt excessive worry (occurring more days than not), for at least six months? This might include unreasonable worry about events or activities, such as work, school, or your health, with an inability to control the worry.

- 1. Yes, in the past month
- 2. Yes, in the past 12 months
- 3. Yes, but it was more than 12 months ago
- 4. No, never

How old were you the first time this happened?

- 1. 0-12 yrs
- 2. 13-19 yrs
- 3. 20-29 yrs
- 4. 30-39 yrs
- 5. 40 yrs or more
- 6. Don't know

How many times have you felt this way?

- 1. 1-3 times
- 2. 4-9 times
- 3. 10 or more times
- 4. Don't know

Are you currently receiving treatment for any of the following? (Tick all that apply)

- 1. Anxiety
- 2. Stress
- 3. Depression
- 4. None of the above

In the past, have you received treatment for any of the following? (Tick all that apply?)

- 1. Anxiety
- 2. Stress
- 3. Depression
- 4. None of the above

We have one more question that will help us to decide how to get information to men.

In your opinion, what are the best ways to get information and strategies to men who are experiencing depression and/or suicidal thoughts? (Select one or more options)

- 1. Facebook or other social media
- 2. Through online chat rooms
- 3. Online ads
- 4. A powerful ad campaign directed at men

## Men's Experiences Survey

5. 5. High profile men talking in the mainstream media about their experience of depression and/or suicidal thoughts
6. 6. A central online source of information about depression and suicidal thinking and where to get help
7. 7. An information or education campaign run through general practitioners
8. Other

That's the end of the survey questions. Before you go, we'd like to check again to see how you're feeling.

For each item below, please provide a rating from 0 (not at all) to 10 (extremely):

	0	1	2	3	4	5	6	7	8	9	10
How sad are you feeling right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How irritable are you feeling right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How agitated are you feeling right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How anxious are you feeling right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Triggered if high levels of distress indicated) Were concerned you are having a tough time now and we do recommend that you get some help. Would you like to be contacted by Lifeline? We have an arrangement with Lifeline for this research project to provide help if people would like it. If you enter your contact details in the box, we (the research team) won't know what you talked about with Lifeline. Any contact you have with Lifeline will remain confidential. At the end of the project, Lifeline will just report to us on how many people they contacted during the study but will not give any details about individuals. Yes, I would like to be contacted by Lifeline in the next 24hrs. Please click here to submit your phone number. Otherwise, please click Continue to resume the survey.

That's the end of our questions. Once again, thank you for sharing your experiences with us. Your answers will help other men in the future. If you are feeling upset right now and would like to speak with someone, Lifeline has counsellors available 24 hours a day on 13 11 14. Sometimes it can help to speak with a kind stranger. Speaking with your GP can also help. The Black Dog Institute website provides advice on finding mental health professionals at <http://www.blackdoginstitute.org.au/public/gettinghelp/consultingaprofessional/index.cfm>

## 1. Men's Experiences Survey - men

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STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation	
Title and abstract	1	(a) Indicate the study’s design with a commonly used term in the title or the abstract	✓
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	✓
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	✓
Objectives	3	State specific objectives, including any prespecified hypotheses	✓
Methods			
Study design	4	Present key elements of study design early in the paper	✓
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	✓
Participants	6	(a) Cohort study—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up	
		Case-control study—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls	
		Cross-sectional study—Give the eligibility criteria, and the sources and methods of selection of participants	✓
		(b) Cohort study—For matched studies, give matching criteria and number of exposed and unexposed	
		Case-control study—For matched studies, give matching criteria and the number of controls per case	
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	n/a
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	✓
Bias	9	Describe any efforts to address potential sources of bias	✓
Study size	10	Explain how the study size was arrived at	n/a
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	✓
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	✓
		(b) Describe any methods used to examine subgroups and interactions	n/a
		(c) Explain how missing data were addressed	n/a
		(d) Cohort study—If applicable, explain how loss to follow-up was addressed	
		Case-control study—If applicable, explain how matching of cases and controls was addressed	
		Cross-sectional study—If applicable, describe analytical methods taking account of sampling strategy	✓
		(e) Describe any sensitivity analyses	n/a

<b>Results</b>				
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	✓	
		(b) Give reasons for non-participation at each stage	n/a	
		(c) Consider use of a flow diagram	n/a	
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	✓	
		(b) Indicate number of participants with missing data for each variable of interest	n/a	
		(c) <i>Cohort study</i> —Summarise follow-up time (eg, average and total amount)		
Outcome data	15*	<i>Cohort study</i> —Report numbers of outcome events or summary measures over time		
		<i>Case-control study</i> —Report numbers in each exposure category, or summary measures of exposure		
		<i>Cross-sectional study</i> —Report numbers of outcome events or summary measures	✓	
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	n/a	
		(b) Report category boundaries when continuous variables were categorized	✓	
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	n/a	
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	n/a	
<b>Discussion</b>				
Key results	18	Summarise key results with reference to study objectives	✓	
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	✓	
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	✓	
Generalisability	21	Discuss the generalisability (external validity) of the study results	✓	
<b>Other information</b>				
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	✓	

\*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

**Note:** An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at [www.strobe-statement.org](http://www.strobe-statement.org).