Perspective

Suicide and the reluctance of young men to use mental health services

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Abstract

Young men are grossly over represented in Irish suicide statistics, yet this group is the least likely to use mental health services. This paper outlines why young men are reluctant to access mental health services, framing the problem in the context of risk factors for suicide such as binge drinking and social change. The paper argues that de-stigmatising mental illness and encouraging young men to seek help for emotional problems should be a priority for policymakers.

Key words: Suicide; stigma; mental health services; young men; binge drinking.

Introduction

In 1998 the UN expressed its concerns about the prevalence of suicide among teenagers in Ireland.[1] Ireland has the fifth highest rate of youth suicide (15-24 years) in Europe and the ratio of male to female suicides is 4.5:1.[2] The discrepancy between male and female suicide rates is also found in international figures.

According to figures based on 82 countries, males have a higher rate of suicide than females in every country but China.[3] In the case of China the higher female rate is driven by females in rural areas where a lack of opportunities and the ready availability of pesticide are leading to fatal incidents of self poisoning.[4] In such areas the vast majority of women are illiterate[5] and have low political participation.

In some countries in Asia, the Caribbean, and Central America female suicides between the ages of 15-19 outnumber those of males.[6] In these regions young women are more vulnerable to sexual violence, spend less time in school, and have fewer economic opportunities than young men.[7]

In western countries however, figures for female suicides are consistently lower than those for men. This is often attributed to the methods of suicide employed by males, which tend to result in greater fatalities.[8]

This paper considers other factors which may contribute to the higher rate of male suicide; such as abuse of alcohol among young men and gender socialisation, which discourages young men from seeking help for emotional issues, meaning that mental health problems go unnoticed in many cases.

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Mental illness

It is widely believed that the majority of suicides have a psychological illness at the time of their death. Studies of suicide victims have found that 40%-70% had a mood disorder.[9] Despite this 75% of men had not accessed a health service in the month prior to their suicides.[10] Males tend to deal with emotional problems by themselves, often using alcohol to self-medicate.[11] The dangers of alcohol abuse are well documented and there is compelling evidence to suggest that such abuse is associated with suicide.[12-14]

Alcohol consumption in Ireland

During the period 1989-1999 alcohol consumption per capita in Ireland increased by 41%.[15] Increases in alcohol consumption per head have been associated with suicide among 15-24 year olds.[16] A recent Irish study showed that the majority of male suicides had alcohol in their blood system and levels tended to be higher in those below the age of 30.[17]

Studies have also shown an association between alcohol consumption and major depression.[18,19] Alcohol abuse significantly lowers a person's mood, particularly in the case of someone with major depressive disorder.[12] The disinhibiting effects of alcohol, on such individuals, may result in suicidal acts which may have been thought of previously, but never acted on.[12] Had these people accessed mental health services to tackle their depression there is a chance they may not have taken such drastic measures.

The Department of Health and Children[20] recommend that adolescent addiction services be delivered separate from adult addiction services and that these services be: delivered locally, holistic in approach, and with family involvement. The Department[21] also recommend that addiction problems should only be treated by mental health services in cases where there is a primary mental health problem. Though the former recommendation may prove helpful in the treatment of adolescent addiction, by increasing family involvement, it is difficult to envisage any possible benefits gained by the latter recommendation, particularly when so many addiction problems coincide with mental health problems. Neither is this recommendation likely to reduce the stigma attached to such services.

Stigma

The Health Service Executive and the Department of Health and Children cite the stigma surrounding mental health problems as a barrier to seeking help for many young people.[22] One Irish study found that young single men, those over 65 and people from the farming community were the least understanding about depression.[23] An Australian study found that 39% of male students would not use a formal

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service for emotional or personal problems.[24] The most important barrier to use of these services was concern over confidentiality.[24] Other studies have found that anticipated shame and embarrassment were barriers to the use of mental health services among young men.[25,26] Barney *et al*[27] surveyed 1,312 adults in an Australian community and found that many would be embarrassed to seek professional help and feared the negative reaction seeking such help might cause. Stigma, therefore, can cause people to delay seeking treatment so that they are not labelled 'mentally ill'. Another issue, however, is that men feel particularly stigmatised when it comes to expressing themselves emotionally.[28] Evidence suggests that this may be due to gender socialisation.

Gender socialisation

Gender socialisation occurs through expectations by parents, teachers, peers, and the media, about what constitutes masculinity.[29] Though there is little difference between the emotions men and women experience[30] there is a large difference in the acceptability of expressing these emotions. At a young age boys are required to restrict their vulnerable or caring emotions.[29] It is almost axiomatic that men do not show their feelings.

Studies have shown that men show more restricted emotionality and restricted affection than women.[31] Leverenz[32] writes of a masculine, competitive arena; where less than masculine behaviour can lead to public humiliation. In such an environment it is important to maintain a 'stiff upper lip'. In a study of American college students, the primary barrier to use of counselling services was male students' socialisation to be independent and conceal their vulnerability from others.[25] As men are socialised to ignore their feelings, poor health can emerge suddenly.[33]

Many men find it difficult to speak to their doctors about stress or mental health problems.[34] Young men are significantly less willing than other groups to contact their GP about psychological issues.[35] One study in the US found that young men considered asking for help a sign that they had 'lost' and that losing was unacceptable for a man.[36] Men are also less likely, than women, to talk to family and friends about their problems and are less likely to use psychiatric services.[37] Instead, they deal with emotional problems by externalising them and 'acting out'.[38]

Men view depression as a threat to their masculinity.[34,37] When males do access psychiatric services it is often through means which do not compromise their masculine self-concept, such as suicide attempts and panic attacks.[39] Young men are also significantly more likely than women or older men to dismiss depression as 'feeling sorry for themselves'[40] and are less likely than women to recognise a mental health problem.[36,41]

Looking at modern Ireland one might ask is gender socialisation as much of an issue today as in previous decades? Although gender roles may be less rigid, in terms of occupation and opportunity, there is no evidence to suggest that men have become more expressive or more willing to discuss emotional problems. Although there have been huge changes in Irish society in the past 20 years, the willingness of Irish men to seek help for emotional issues seems to be unaffected. In fact there is evidence which indicates that social change itself is a factor in suicide.

Social change

The World Health Organisation identified the problems experienced by adolescent boys as a result of "…changes in the roles of boys and men in society, accompanied by changes in developmental and economic possibilities and opportunities".[42] Durkheim[43] argues that abrupt transitions in society result in 'anomie', a term which describes a breakdown of social norms, and an increased suicide rate. There is some research to suggest that countries undergoing economic and social change do experience increased suicide rates.[44] This effect can be seen in Eastern Europe,[45] China[46] and Ireland.[47] Kelleher,[47] looking at suicide rates from 1970-1985, suggests that the increase may be due to changes in the cohesiveness of Irish society as well as changes in the values of Irish society. Ireland experienced an increase of 154% in male youth (15-24) suicide rates between the years 1980-1990.[48] In Britain, factors most consistently associated with rises in young male suicide are increases in divorce, declines in marriage and increases in income inequality.[49] During the period 1970-1990 marriage rates in Ireland fell from 7% to 5.1%.[50] The separation rate in Ireland nearly doubled between the years 1986-1996[51] and, in later years, inequality became more pronounced as the economy boomed.[52]

A lack of awareness and knowledge

A recent study in primary and secondary schools in Dublin found that students showed little awareness of the role of mental health professionals in treating individuals with problem behaviour.[53] Other Irish studies have found that young people do not know where to get help for depression.[28,36,54,55] This is consistent with international studies.[25,36] These studies indicate that mental health promotion is in need of revision and young people need to be better educated about mental illness; as this gap in information is creating a barrier to their use of mental health services.

How is the problem of suicide being dealt with?

The government's response to the rise of suicides among young people has been to set up organisations to monitor and investigate the trend. The National Task Force on Suicide, the National Suicide Research Foundation, the Irish Association of Suicidology and the National Suicide Review Group were all established between 1995-1998. In addition, a number of regional health boards have published suicide prevention strategies.

The National Strategy for Action on Suicide Prevention 2005-2014, listed priority areas of service development in the 2005 *Reach Out* report.[22] The report's objectives focused on: response to self-harm, mental health service provision, alcohol and substance abuse, marginalised groups, prisons, police response to suicidal behaviour, victims of abuse, supports for young men, supports for older people, and restricting access to means of suicide.

Most of the attention and focus of the Government's response to suicide has been concerned with how to deal with the factors which drive suicide, such as: unemployment, alcohol and drug misuse, physical abuse, and confusion over sexual orientation; as well as the services which are in place to care for people with a mental illness. The need to target poverty and social exclusion has also been emphasised as a

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means of reducing the suicide rate in Ireland.[56] While such areas are hugely important we should bear in mind that much less attention has been paid to the issue of stigma and young people's reluctance to use mental health services. No matter what improvements are made to the infrastructure of mental health services it will not make an impact unless young people are willing to use them.

What can be done?

The *Reach Out* report[22] mentions the importance of removing the stigma attached to mental illness but does not specify how this is to be carried out. The World Health Organisation[57] recommends community care as a way of limiting the stigma of being treated for a mental illness. This surrenders to, rather than confronts, the stigma attached to mental illness. Patients should not be stigmatised by receiving treatment, regardless of the context of that treatment. Instead, strategies to diminish stigma should be initiated, such as: education, advocacy, and open discussion of mental illness.

There is a need for mental health education at all stages of the school curriculum, with particular emphasis on reducing stigma.[58] Young men need to know how to deal with their negative feelings constructively, instead of numbing them with alcohol or engaging in high risk activities. They also need to be made aware of the signs of mental illness, so that they may recognise poor health in themselves and others. More information needs to reach young men in terms of the mental health services that are available to them. The role of GPs, counsellors, and psychiatrists should be clearly explained to them. Also, there should be a clear and easy-to-follow protocol for young men who want to get in contact with these professionals.

In Australia, ORYGEN Youth Health was launched in 2002. The organisation provides a series of programmes to assist young people with mental health problems. These include a 24-7 youth access team, which assesses those referred to triage and offers crisis response, and a Youth Participation Programme which encourages young people to become mental health advocates.[59] In Austria, a programme focusing on training teachers to recognise problems in students was launched in 2001. The programme entitled 'Step by Step' was evaluated favourably by the schools involved.[60] Another Australian initiative, 'Beyondblue', aims to destigmatise mental illness by increasing public awareness. Analysis of its progress suggests that there have been improvements in social attitudes towards depression.[61]

Since 2001 social, personal and health education (SPHE) has been taking place in primary schools and in the junior cycle of post-primary schools in Ireland.[62] The aims of SPHE are to promote self-esteem and well being, to enable students to make responsible decisions, and to develop skills for living in communities.[62] One module of SPHE focuses on 'Emotional health' and emphasises the importance of recognising feelings and respecting the feelings of oneself and others. It would be worthwhile to include a segment on help seeking, as this is a key issue in promoting mental well being.

Aware also run an education programme in schools. The program, which is called 'Beat the Blues', is designed to inform young people about depression. In seven academic years, over 100,000 students nationwide have been spoken to.[63]

Structural stigma also needs to be addressed. While 20%-30% of all health disability is related to mental health problems, mental health services have access to only 7% of the national health budget.[64] Furthermore this percentage has decreased from 10.6% in 1990.[64] At a time when suicide in Ireland is climbing, this cannot be justified.

Stigma is also a problem in the workplace. Research has shown that while one third of Ireland's workforce has had depression,[65] workers are reluctant to disclose depression to their employers for fear of negative consequences.[66,67] This feeds into public and self-stigma of depression and needs to change. Employers must support workers who disclose mental health problems in order to create an atmosphere of tolerance for mental health issues. If workers feel safe disclosing their problems to employers, it may set a precedent for disclosure to other people who are in a position to help.

Conclusion

Ireland has seen a rapid increase in suicide rates in young people, and young men in particular. While much attention has been paid to what is causing this increase in terms of stressors, little attention has been paid to the barriers which prevent young men from seeking help. These barriers include gender socialisation, stigma, and a lack of awareness about mental health professionals and the services that they offer. Policymakers need to address these issues in order for any preventative strategies to be effective.

In order to properly educate young people about mental illness it is necessary to incorporate mental health education into the school curriculum as early as possible. Teachers, parents, and policymakers need to place the same emphasis on mental health as they would on physical health; for it is these groups who will be instrumental in changing the way mental illness is discussed and, therefore, perceived.

Open discussion of mental illness will not only inform young people; it will also help to de-stigmatise mental illness generally. Stigma is an enormous obstacle for people in need of mental health services. A fear of being labelled makes many people reluctant to seek treatment. The message to young people needs to be loud and clear: having mental health problems is nothing to be ashamed of.

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