Can men talk if their lives depend on it? Gender differences in a dialogue-based suicide intervention programme at Pieta House, Ireland

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Abstract

There are well-established gender differences in the content and style of communications and in help-seeking behaviour. Given that the Pieta House Suicide Intervention Model (PH-SIM) is a dialogue-based therapy there was concern that the model would be less effective for males than females. This research aimed to compare the outcomes for male and female clients one month after completing treatment at Pieta House. A repeated measures design was employed and involved administering a questionnaire assessing levels of self-esteem, depression, deliberate self-harm, and suicidal ideation pre-treatment (by a therapist) and one month after treatment had been completed (via telephone by independent researchers). From the total sample of 664, analyses were based on the 52 clients (half male, half female) that completed all items in both conditions. The main findings include significantly higher self-esteem and positive suicidal ideation (i.e., reasons for living), and significantly lower depression and negative suicidal ideation (i.e., reasons for dying) following engagement with the PH-SIM, and no significant differences in scale scores by gender, suggesting that male and female clients benefitted equally from this dialogue-based intervention model. These indicate that the main issue for male suicide intervention programmes is not the ability of men to engage in or benefit from the dialogue-based treatment model, but in taking the first step to actually engage in therapy.

Introduction

The prevalence of male suicide is perhaps best illustrated by Joiner's (2005) revelation that, with the exception of China, more men complete suicide every year in every country in the world. In the United States, men are more than four times as likely as women to complete suicide (Coleman, Kaplan, & Casey, 2011) and Payne, Swami, and Stanistreet (2008) state that in England and Wales men are three times as likely to complete suicide as women, with Greece and Ireland demonstrating the widest gap between men and women for suicide mortality.From a treatment perspective this problem is compounded by gender differences in communication styles and abilities.

The aim of this research, therefore, is to determine whether the Pieta House Suicide Intervention Model (PH-SIM), the dialogue-based treatment model used by Pieta House, is less effective for male than for female clients.

Gender and Suicide

While research has suggested that there is little difference in the quantity of verbal communication of men and women (Mehl e al., 2007) it has posited a gender difference in the context and content of communication. Men tend to engage in more fact-based 'report talk' (Tannon, 2003) and are more talkative in a public arenas, while women have a greater tendency for relationship building 'rapport talk' and talk most frequently in a private capacity (Leaper & Ayres, 2007).

It has been suggested that such gender differences in communication are established at an early age. Pollack (2006) states that males are encouraged to hide their emotions from the age of three through 'gender straitjacketing', by which toughness is valued and rewarded at the expense of emotional expression or vulnerability. As a result, men are socialised to believe that more emotional communication is less masculine and so expressing fear or sadness is difficult for men as it exposes vulnerability (Rubin, 2004).

When applied to Baumeister's (1990) escape theory of suicide, when emotional difficulties result in a narrowing cognitive state of limited emotion males have few perceived emotional outlets, while females are more likely to turn to friends (Jones, 1990) or healthcare professionals for help (Hawton, 1998; 2000). A plausible extrapolation of this male proclivity for a less emotionally divulging communication style is that suicide intervention models based on dialogue, such as the PH-SIM, may be less effective for males than for females.

Suicide in Ireland

Officially 525 people died by suicide in Ireland in 2012 (Central Statistics Office, 2012). However, given that the majority of undetermined deaths are likely to be suicides (Linsley et al, 2001) and research from Ireland reported that a suicide note, e-mail or text message prior to death was present in 16.7% of open verdicts investigated (National Suicide Research Foundation, 2012), it is likely that this figure is considerably higher.

Youth suicide in Ireland is the fifth highest in the EU, and rates are particularly high among young men aged 16–34 years, accounting for almost 40% of deaths in 2003 (National Office for Suicide Prevention, 2005). Recent figures show that Irish men are significantly overrepresented in deaths by suicide (National Suicide Research Foundation, 2012), are fifteen times more likely to die from firearms-related suicide (Sarma & Kola, 2010), and are increasingly likely to engage in deliberate self-harm, the most important risk factor for suicide (Hawton & Van Heeringen, 2009) (a 27% increase for males compared to a 5% increase for females since 2007, (NSRF, 2011)).

The association between economic recession and increased risk of suicide is well established (Barr, Taylor-Robinson, Scott-Samuel, McKee, & Stuckler, 2012; Reeves, Stuckler, McKee, Gunnell, Chang, & Basu, 2012), and is particularly pertinent in contemporary Ireland. During the Celtic Tiger (1995 to 2008), Ireland was transformed from one of the poorest countries in Western Europe to one of the wealthiest. Within a few years the Irish unemployment rate was the sixth highest across Europe, government debt was almost two-thirds of GDP (CSO, 2010), and residential and commercial property prices had dropped by up to 60% (Daft.ie, 2013). Furthermore, the industries most affected by the economic downtown are construction and agriculture (NSRF, 2012), two traditionally male dominated sectors.

Pieta House

Pieta House provides free one-on-one therapy for individuals and families that have been affected by suicide or deliberate self-harm. Clients can self-refer, and all therapists are accredited by the Irish Association for Counselling and Psychotherapy. Pieta House was founded in 2006 on Shneidman's (1985) assertion most suicidal individuals do not wish to die but cannot imagine continuing to live in their current state of psychological turmoil (Shneidman, 1996). Pieta House supports the proposition that suicidal crises, if successfully navigated, doesn't have to be fatal.

The treatment model develops the suicidal individual's protective factors in order to overcome their current suicidal crisis and act as a buffer for future crises. The aim of the model is to identify and promote reasons for living while simultaneously identifying and addressing reasons for dying. The PH-SIM has three stages (see Figure 1):

- Pre-treatment: identify those who are suitable for treatment
- Treatment: 15 sessions where the client develops protective factors in three aspects of their life linked to human contentment (Jeffers, 1988): three addressing physical needs; three for emotional; and three for spiritual. The process employs elements of CBT and DBT.
- Follow-up: Involves contacting clients 2, 4, and 6 weeks after treatment has been completed

Given the central role of emotional disclosure and intimate discussion there were concerns that men and women may not benefit equally from a dialogue-based intervention model.

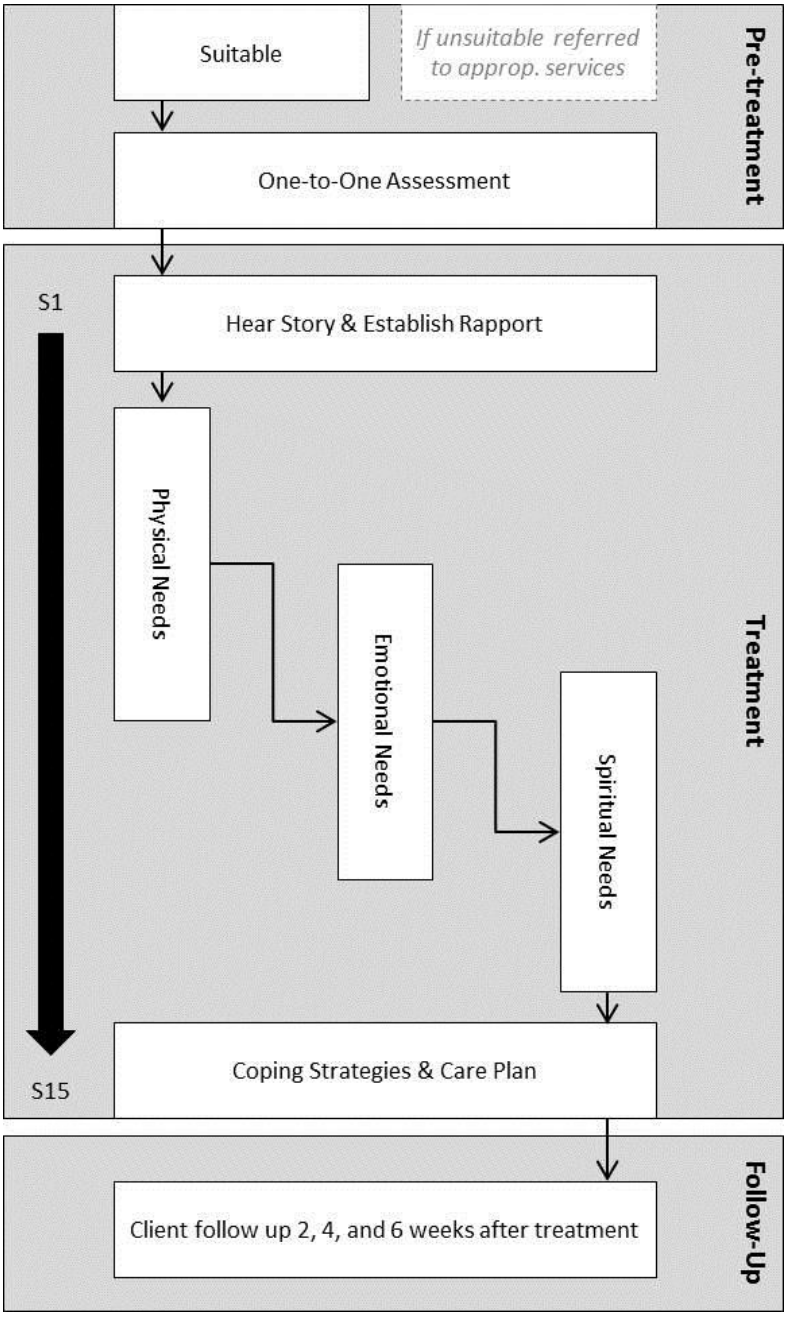

***Figure 1**: The Pieta House Suicide Intervention Model (PH-SIM)*

Aims

Given the greater tendency for males to die by suicide and gender differences in communication, this research aimed to ascertain whether male and female clients benefited equally from the dialogue-based suicide intervention model used by Pieta House. This was established by testing the following hypotheses:

- Treatment will increase the client's self-esteem, regardless of their sex
- Treatment will decrease the client's levels of depression, regardless of their sex
- Treatment will increase the client's positive suicidal ideation and decrease their negative suicidal ideation, regardless of their sex
- Treatment will decrease the frequency of the client's deliberate self-harm, regardless of their sex

Methodology

A quasi-experimental, one-group, repeated measures design was employed to establish gender differences in the effectiveness of engaging of the PH-SIM.

Experimental design

The repeated measures design allows the researcher to make comparisons with the same participants before and after treatment rather than with non-treatment conditions. The main advantage of this design is that it is often more accurate than the independent measures design because individual differences between participants are removed as source of confounding variables. Since participants serve as their own controls this reduces the error variance and increases the statistical power of the test (Ellis, 1999). The design can attain or exceed the level of statistical power of a between-subjects design with fewer participants (Cohen, 1988) and provides tight scientific control over threats to internal validity (Huck & McLean, 1975). While the design has been criticised for its internal validity due to order effects such as practice effects or fatigue the impact of both on this study is somewhat limited by the fact that there is only one intervention condition.

The study employed no control group, other than the control inherent in repeated measures designs by assessing the same clients in the pre and post treatment conditions. Control groups are included in an intervention study to address the issue of change that may occur without the influence of the intervention condition or the client's expectations (Street & Luoma, 2002). However, the introduction of a control group would necessitate that some clients presenting to Pieta House would not receive the treatment available to others to serve as a comparable control. This is contrary to the advice of the World Medical Association (1997) and raises considerable ethical concerns. Based on the consideration of the principles outlined in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979), particularly the issue of beneficence (i.e., the risk to the client, the long-term impact, and increased hopelessness and despair if left untreated) it was decided to forgo a control group.

Sample

The sample contained adults who presented to Pieta House with suicide ideation, a history of suicide attempts, or were engaging in deliberate self-harm, and completed their treatment to the

satisfaction of their therapist. Clients were either self-referred (35.9%), referred by family or friends (40.9%), or referred by education or health authorities (23.2%).

For ethical and practical reasons, it is important to accurately estimate the required sample size when testing an hypothesis or estimating the size of an effect in observational research (Delucchi, 2004). A power analysis using the G*Power 3 programme (Faul et al. 2009) indicated that a total sample of 8 people would be needed to detect large effects (d=.8) with 96% power using a repeated measures ANOVA with alpha at .05.

Participants

The total sample included 664 clients. Over half (58.9%) were female and all clients, as required, were over 18 years old. Almost two-thirds of clients presented for treatment due to a suicide attempt or suicidal ideation only (65.2%), 8.2% presented for deliberate self-harm only, and 26.6% presented for a combination of suicidal ideation and deliberate self-harm.

Research Tools

Treatment with the PH-SIM is considered to be effective if the client has lower levels of depression and suicidal ideation, higher levels of self-esteem, and more reasons for living. The questionnaire contained the following measures:

> *Self-Esteem:* Defined as a person's appraisal of his or her value (Leary & Baumeister, 2000), the association and predictive validity of self-esteem with suicide is well-established (Chatard, Selimbegović, & Konan, 2009). The Robins, Hendin, & Trzesniewski's (2001) self-esteem scale is a single-item indicator ("I have high self-esteem") rated on a five-point scale ranging from one (not very true of me) to five (very true of me). The Single Item Self-Esteem Scale has very high convergent validity with the Rosenberg Self-Esteem Scale (Rosenberg, 1965) for males and females, different ethnic groups, for different occupational statuses, and for a 5-point and 7-point rating scale, as well as a nearly identical pattern of correlates as the Rosenberg Self-Esteem Scale with a wide range of criterion variables.
>
> *Depression:* The Patient Health Questionnaire (PHQ-9) is a nine item depression scale for assisting in diagnosing and assessing the severity of depression (Kroenke, Spitzer, & Williams, 2001). In addition to well-established reliability and validity, when administered face-to-face (Martin et al., 2006) or over the telephone (Pinto-Meza et al., 2005), recent research has suggested that the PHQ-9 is a feasible measure for detecting depression in many groups and may be useful in identifying individuals at risk for suicide who would not otherwise have been identified (Uebelacker et al, 2010). The scale asks clients about the frequency of activities over the past two weeks relating to eating, sleeping, energy and motivation levels, and responses range from zero ('not at all') to three ('nearly every day').
>
> *Positive and Negative Suicidal Ideation:* Dugas et al. (2012) refer to suicidal ideation as thoughts about self-destruction, including the idea that life is not worth living, wishing to be

dead, and specific plans to end one's own life. The Positive and Negative Suicide Ideation Inventory (PANSI) (Osman et al., 1998) is designed to assess the frequency of negative risk and protective factors associated with suicide-related behaviours based on the rationale that both negative risk and protective (buffering) factors are important in the analyses of suicide-related behaviours (Osman et al., 2002). Four items were selected from the positive ideation scale (2, 12, 13, and 14) and four from the negative ideation scale (1, 3, 5, and 11) based on the strength of the factor loadings on the confirmatory factor analysis conducted by Osman et al (2002), giving a total of 8 items. A sample positive scale item is "During the past two weeks, including today, how often have you felt confident about your ability to cope with most of the problems in your life?", while a negative item is "During the past two weeks, including today, how often have you seriously considered killing yourself because you could not live up to the expectations of other people?". Suicide ideation is addressed by the negative ideation scale items while the desire to live is addressed by the positive ideation items. Some minor changes were applied to the wording of the questions to keep it consistent with the terminology used at Pieta House (e.g., 'killing yourself' was replaced with 'dying by suicide').

Procedure

All clients that fulfilled the research criteria (i.e., were over 18 years old, had completed treatment to the satisfaction of the therapist, and had signed the consent form) were provided with an information sheet and invited to participate in the research. The rate of consent was 56.7%. The first questionnaire was administered by the therapist at the initial assessment, before any treatment had commenced. The questions were read aloud by the therapist and the responses captured on the questionnaire. Participants were subsequently called by independent researchers within a month of completing their treatment and the same questions administered.

A small pilot study was conducted with 40 clients who had completed treatment to test the questionnaire items and the telephone procedures. While this highlighted some procedural issues the questionnaire remained unchanged.

The study received the ethical approval of the research ethics committee at the Adelaide & Meath Hospital, Incorporating the National Children's Hospital in Dublin.

Results

This research aimed to determine the presence and extent of gender differences in the effectiveness of the PH-SIM. This section begins by providing a breakdown of the sample by gender and establishing the reliability of the scales used, and then analyses are presented on the effectiveness of treatment on the group as a whole, before considering the impact of treatment by the sex of the client.

Sample

In the total sample for analysis (n=664) 45.8% were male, 86% presented with suicidal ideation, and 14% presented due to deliberate self-harm. Clients were excluded listwise leaving only those who had a complete dataset for both conditions. This resulted in a sample of 52, of which half was male (n=26) and half female (n=26). Over three-quarters of this group presented with issues related to suicide, 19.2% (n=10) presented with both suicide and deliberate self-harm, and only 2 of these clients (3.8%) were attending Pieta House.

Scale Analysis

The internal consistency of each scale (with the exception of the single-item indicator) was assessed. The Cronbach alpha values for the PHQ depression scale (.88), Deliberate Self-Harm Inventory (.85), and the PANSI Positive Suicide Ideation (.80) and Negative Suicide Ideation (.91) scales would be categorised as 'good to excellent' using George & Mallery's (2003) recommended classification.

Pre- and Post- Treatment Scale Scores

Dependent samples t-tests were conducted to determine whether clients' scores on each of the scales changed as a result of the treatment intervention. Statistically significant differences between pre- and post- levels were found for all measures.

Scale	N	Pre-Treatment		Post-Treatment	
		Mean	SD	Mean	SD
Self-Esteem	48	1.67	.953	2.83	1.078
Depression	50	18.12	5.498	10.34	7.350
Positive Suicide Ideation	43	9.53	3.680	13.74	3.546
Negative Suicide Ideation	45	13.27	4.293	7.58	4.624

Table 1: Mean Scale Scores for Clients Pre- and Post- Treatment

Mean self-esteem scores were higher ($t(47)=-6.50$, $p < .001$) after intervention. Scores on the PHQ depression scale were lower ($t(49)=6.57$, $p < .001$) suggesting lower levels of depression following treatment. Suicide ideation is measured by positive and negative sub-scales: for positive suicide ideation (i.e., reasons for living) scores were higher ($t=(42)= -5.14$, $p < .001$) while mean negative suicide ideation scores (i.e., reasons for dying) were lower ($t(44)=7.61$, $p < .001$). All of these differences were statistically significant.

Scale Scores Pre- and Post- Treatment, by Gender

A repeated measures analysis of variance (rANOVA) found no statistically significant difference between male and female scores pre- and post- treatment for any of the conditions.

	Male					Female				
		Pre-Treatment		Post-Treatment			Pre-Treatment		Post-Treatment	
	n	M	SD	M	SD	n	M	SD	M	SD
Self-Esteem	25	1.88	1.09	2.92	1.08	23	1.43	0.73	2.74	1.09
Depression	26	17.73	6.27	9.88	8.62	24	18.54	4.62	10.83	5.82
DSH	-	-	-	-	-	6	5.17	5.08	9.00	11.12
Positive suicide ideation	23	10.78	4.06	13.87	3.89	20	8.10	2.61	13.60	3.20
Negative suicide ideation	25	12.92	4.21	8.00	5.20	20	13.70	4.46	7.05	3.85

Table 2: Mean Scale Scores for Clients Pre- and Post- Treatment, by Gender

Analyses for males only verified that the differences for self-esteem ($t(24)=-4.19$, $p < .001$), depression ($t(25)=3.92$, $p < .001$), positive suicide ideation ($t(22)=-2.65$, $p < .01$), and negative suicide ideation ($t(24)=4.78$, $p < .001$) were all statistically significant.

Discussion and Conclusions

The aim of this study was to ascertain whether male and female clients benefited equally from the dialogue-based suicide intervention model used by Pieta House. Based on the results we can conclude that there are no gender differences in the effectiveness of the PH-SIM.

Based on the single-item indicator clients reported greater levels of self-esteem after they completed treatment at Pieta House. Although males reported higher levels of self-esteem both before and after treatment these were not statistically significant. This is consistent with existing research where older studies (Kearney-Cooke, 1999; Kling et al., 1999) suggested a small but significant difference in self-esteem in favour of males and more recent studies (Erol & Orth, 2011) suggest no significant gender differences. In relation to the PH-SIM this would suggest that treatment was equally effective for males and females, regardless of their levels of self-esteem before treatment. The lack of significant differences after treatment completion suggests that both males and females benefitted equally in terms of self-esteem.

Following treatment at Pieta House the severity of clients' depression was significantly lower after treatment. A slight decrease in depressive symptoms would be expected, regardless of intervention, as Wasserman et al. (2012) commented there is a relief associated with surviving a suicide attempt. However, this relief tends to be short-lived and is frequently replaced by discomfort and suicidal ideation shortly afterwards. The effectiveness of the treatment is supported by the fact that

depression levels were still significantly lower up to a month after the completion of treatment. There were no significant gender differences in levels of depression following treatment, suggesting that therapy was equally effective for male and female clients.

The PANSI scale (Osman et al., 1998) is comprised of the positive suicide ideation scale and the negative suicide ideation scale, both of which were considered important in the analysis of suicide related behaviours (Thompson, Eggert, & Herting, 2000). Negative risk factors in suicidal behaviour such as depression, hopelessness, and negative or perceptions of stressful events may increase the risk for suicidal ideation, while positive factors modulate against suicidal ideation (Osman et al., 2002). Scores on the Positive Suicide Ideation scale were significantly higher after treatment, suggesting that clients' protective factors, coping mechanisms, and positivity towards the future have been enhanced through their therapeutic engagement. There were no statistical differences in scale scores by gender. Similarly there were no statistical differences in scales score by gender on the Negative Suicide Ideation scale. The significant decrease in negative scale scores suggest that the clients' desire to die by suicide had decreased and had remained lower than when they first presented to Pieta House. The significant differences of both measures in conjunction with each other suggests that rather than being one-dimensional the treatment model is effective in simultaneously developing the client's sense of fulfilment and positivity, along with reducing the clients' desire to die by suicide. Addressing these issues together and within a limited timeframe is important since most suicide attempts occur within the first year after the onset of suicidal ideation (Nock et al., 2008).

There were several major conclusions from this research. The first was that following engagement with the PH-SIM clients reported significantly higher self-esteem and positive suicidal ideation, and significantly lower depression and negative suicidal ideation. The second was that there were no significant differences in scale scores by gender suggesting that male and female clients benefitted equally from this dialogue-based intervention model. The third was that although a similar proportion of males and females had a history of attempted suicide, the larger number of female than male clients suggested that males were less likely to seek help. The combination of these factors suggest that the main issue for male suicide intervention programmes is not their ability to engage in or benefit from the dialogue-based treatment model, but in taking the first step. Research has revealed that that of the 2.1% of men seeking outpatient help for depression in America in 2007, less than half engaged in therapy while almost three-quarters (73.3%) used prescription medication (Marcus & Olfson, 2010). Cleary has written extensively on masculinity and suicide in Ireland (Cleary, 2005a, 2005b, 2012a, 2012b) and the male preference for non-disclosure and seeking solutions to their problems via more culturally acceptable outlets such as alcohol. Such behaviour inevitably compounds rather than alleviates their problems and results in seemingly insurmountable pain or psychological anguish associated with Baumeister's (1990) escape theory of suicide. Future focus, therefore, should be on initiatives that help to education people on the signs and symptoms of suicidal ideation, in promoting awareness of how to address the issue of suicide with male friends, colleagues, or family members, and in encouraging men to take the necessary steps towards engaging in therapy.

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