Suicide and Male Workers

Men commit four of every five suicides, frequently in the context of a business or work failure. EA professionals are in an ideal position to assess for suicide risk.

by Douglas G. Jacobs, M.D.

In May 2001, the Office of the Surgeon General of the United States launched an initiative to promote awareness of suicide as a public health problem and encourage the development of suicide prevention programs. Although the suicide rate in the United States declined in the decade leading up to the release of the initiative, suicide is still the 11th-leading cause of death in the United States. More Americans kill themselves each year than are killed by other people.

The overall suicide rate in the United States is about 11 per 100,000. But that figure obscures a startling discrepancy, which is that suicide is primarily a male problem. In women, the suicide rate is between 5 and 7 per 100,000; for men, it's between 18 and 20. Men commit four of every five suicides, although 75 percent of suicide *attempts* are made by women. If you look at the demographics of suicide fatalities in men, the suicide rate is about the same from age 15 up to the age of 50, rises slightly from age 50 to 60, then increases dramatically after that.

What can we make of these statistics? Unfortunately, our understanding of gender distinctions related to suicide is minimal. We do know, however, that whereas women tend to commit (or attempt) suicide in the context of an interpersonal failure, men tend to commit suicide in relation to a business or work failure. The risk of male suicide seems to be greater if there's a fall in status or position; it doesn't appear to be related to one's status within the work organization or one's income bracket.

This information has obvious implications for the workplace. Men in the workplace are primarily between the ages of 20 and 60, and at those ages the suicide rate for males is between 20 and 25 per 100,000. Employee assistance professionals who work with men who are being displaced or demoted should consider them at elevated risk of suicide, though not necessarily "at risk."

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NUMBER-ONE CONTRIBUTOR

How can you determine which employees (if any) are at risk for suicide? The bottom line is that more than 90 percent of people who attempt or commit suicide will have one of three mental health disorders: depression, alcoholism, or schizophrenia. Another 5 percent will have personality disorders. More than 7 in 10 persons who commit suicide have at least two disorders, either a combination of depression and alcoholism or depression and personality disorders.

Depression is the number-one contributor to suicide; that is, if we look at 100 suicides, anywhere between 60 and 70 percent of them would have been diagnosed with depression. However, the vast majority of people who suffer a depressive episode in a given year do not attempt suicide. This points up one of the biggest problems in preventing suicide—we don't have a tool that can accurately predict whether someone is likely to try to take his or her own life. Screening awareness programs are really the state of the art in this area.

Although women are twice as likely to have depression as men, they are also twice as likely to seek treatment. Overall, people with depression tend to commit suicide early during the course of their illness—sometimes during the first or second episode—whereas people with alcoholism tend to commit suicide later in the course of their illness. What this means is that if someone in your organization has alcoholism, s/he may stay sober for 10 years, but if this person's job becomes threatened, relapse may occur and the risk of suicide can increase.

One of the things you'll notice about many people who are depressed is that they also have symptoms of anxiety. In fact, it is estimated that about 70 percent of people with depression have anxiety symptoms. This is relevant in part because one of the mainstreams of treatment today is antidepressant medications in combination with psychotherapy. There's a growing belief that we tend to underuse anti-anxiety agents in the initial phase of depression treatment. I don't mean to promote the whole concept of medication, but if someone exhibits anxiety symptoms in addition to depression, it should be noted and addressed quickly. If not, what frequently happens is that this person may drink a little bit more in an effort to calm down (though alcohol is actually a poor anti-anxiety agent).

A variant of depression is what we

call bipolar disorder. People with bipolar disorder not only suffer from depression, but also have mania. Bipolar disorder can be difficult to assess because these patients typically have a lot of energy and plenty of confidence, and they may well be among your more productive workers. Where they tend to present themselves is when they become irritable or distracted or, at the extreme, provocative or aggressive. These patients can be at elevated risk for suicide and represent challenges in terms of encouraging treatment and treatment compliance.

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UNEVEN PATTERN

If an employee at your work organization has been diagnosed with depression, ask yourself how this person relates to his or her family and when (or even if) it might be appropriate to involve the family. My rule of thumb is that if I have any reason to suspect a person is at risk of suicide, I will breach confidentiality and worry about it later. I think it's important when working with a depressed person to understand his/her support system. That doesn't mean you should contact any family members, but you should know *how* to contact someone and whether the family is a real resource for the patient, because that may be where the problem lies.

You should also ask yourself if work is contributing to someone's level of depression, either because the person is being asked to perform at a level that is beyond his or her ability, a supervisor is being overly critical, or depression is hindering the person's ability to function. It's important to be aware of these various potential scenarios and figure out how best to intervene, if necessary.

It's also important to understand that once someone begins treatment for depression, improvement is not linear—it doesn't go straight up. It's much more uneven, like a sawtooth pattern. This can be a delicate issue in terms of advising depressed employees and their supervisors about work levels. On the one hand, it's good for an employee's self-esteem to be back at work. On the other hand, as I like to tell people I'm treating for depression, "If you had a heart attack, there would be a recovery period, and less would be expected of you at first." Again, you have to ask some questions: What are the demands of this person's job? What adjustments can be made in the person's workload?

Treatment for depression can certainly be very successful and usually shows results in two to four months. It is critical, however, that employees taking medication for depression not stop taking it abruptly if their symptoms improve. Stopping medication abruptly can result in serious symptoms that, although not life-threatening, can be incapacitating and interfere with a person's ability to work.

DARKEST THOUGHTS

Suicide can be a difficult area of inquiry during an assessment for depression. People may be very reluctant to talk openly about their darkest thoughts. Questions to ask may include, "How bad do you feel? Have you ever felt so bad that you've thought life isn't worth living? Have you ever thought about ways you might hurt yourself? Do you have a plan to hurt yourself? Have you done anything to carry out that plan?"

If a client answers in the affirmative to these questions, you will need to delve into some of the details—for example, whether the person has firearms at home or has purchased a rope. If you get a positive answer to this line of questioning, you will want to contact a physician.

There is a genetic component of suicide inasmuch as someone who has had a suicide in his family is four times more likely to commit suicide himself. When conducting a health history, it's important to ask whether there's a family history of suicide and, if so, which relative committed suicide.

The role of trauma and abuse in a family should also be considered when assessing for suicide risk, particularly physical or sexual abuse in the case of women. In the workplace, these women will be appropriately but extraordinarily sensitive to abuse or any issue they might perceive as abuse. Their reactions may be quite severe, and their past abuse needs to be taken into consideration.

The most significant psychological contributor to suicide is a feeling of hopelessness. Hopelessness is defined as negative expectations of the future and is a symptom of depression. When talking with someone who is depressed, you should inquire about his/her level of hopelessness. If someone has a prior history of depression, try to determine whether s/he has had any prior experience with hopelessness.

Some people also suffer, on an ongoing basis, from low self-esteem. These people can be very, very effective workers, but they will often need a lot of support from you and their supervisor. If people who are vulnerable to low self-esteem start to question their self-worth, a domino effect can result and lead to suicidal ideas. Also, if an employee's self-esteem is tied to his/her work and that work is disrupted—say, by a transfer, a downsizing, and/or a demotion—this person will need to be identified and offered additional support.

In sum, if you're involved with someone in the workplace (particularly a man) who expresses suicidal ideas or who you think might be at elevated risk of suicide, find out how serious those ideas are, the strength of the person's support system, if s/he appears to be complying with treatment, and whether there is co-morbid substance abuse before attempting to determine the appropriate level of intervention. Above all, remember that male workers who fit any of the risk categories—depression, alcoholism, or schizophrenia—are especially vulnerable to downsizings and other disruptions related to their jobs. ■