Externalising depression symptoms among Canadian males with recent suicidal ideation:**A focus on young men****Brief Report**

Simon M. Rice^{1,2}, David Kealy³, John L. Oliffe⁴, & John S. Ogrodniczuk³

¹ Orygen, The National Centre of Excellence in Youth Mental Health, Centre for Youth Mental Health, The University of Melbourne, 35 Poplar Rd, Parkville, Melbourne Australia

² Youth Mood Clinic, Orygen Youth Health, Parkville, Northwestern Mental Health, Melbourne Health

³ Department of Psychiatry, University of British Columbia, #420, 5950 University Boulevard, Vancouver, BC V6T 1Z3, Canada

⁴ School of Nursing, University of British Columbia, T201-2211 Wesbrook Mall Vancouver, BC V6T 1Z3, Canada

Corresponding Author: Dr Simon Rice, Orygen, The National Centre of Excellence in Youth Mental Health, Centre for Youth Mental Health, The University of Melbourne, Locked Bag 10, Parkville, VIC 3052, AUSTRALIA. T: +03 9342 2800, E: simon.rice@orygen.org.au

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Abstract

Aim: The primary aim was to quantify, relative to older men, young men's externalising of depression symptoms and past-month suicidal ideation.

Methods: A non-probability national sample of 1,000 Canadian men self-reported internalising and externalising symptoms of depression and past-month suicidal ideation. Stratification quotas reflected Canadian census data to age and region.

Results: Young men (18-25 years) were at markedly higher risk of past-month suicidal ideation than were older men. When controlling for internalising depression, a multivariate age $\times$ recent suicidal ideation interaction indicated higher externalising of depression symptoms in young men relative to older men, especially for those reporting recent suicidal ideation ($p < .001$). Interactions were observed for drug use, anger and aggression, and risk-taking domains. A sizable proportion of younger men were uniquely identified by the MDRS-22.

Conclusions: Screening tools that include assessment of externalising symptoms may assist in improving detection of distress and suicide risk in young men.

Keywords: young men, gender, depression, suicide, masculinity

Current data identifies suicide as a leading cause of death for young males. In Canada, for those aged 20-24, the suicide rate for young males is 15.9 per 100,000 cases (Statistics Canada, 2017). In Australia, male suicide accounts for 24.4% of all deaths of young people aged 15-24 years (ABS, 2016). Similar trends are noted in other Western nations (Kölves K & De Leo, 2016; Linsley et al., 2016; Rodway et al., 2016), where young males are also among the least likely demographic group to seek mental health help (Grace, Richardson, & Carroll, 2016). Given that the peak onset of mental illness occurs in adolescence and early adulthood, there is substantial risk to economically productive years in young men's lives, potentially setting a trajectory of lifelong mental health challenges (Gore et al. 2011).

Reasons for higher suicide rates among young men are diverse, and draw on social determinants of health, low health service utilisation, poor mental health literacy, perceived stigma, cultural expectations, and alignments to traditional masculine norms (Chandra & Minkovitz, 2006; Hawkes & Buse, 2013; Oliffe et al., 2010). A potential additional factor may concern current diagnostic and screening criteria for depression: a focus on internalising symptoms is thought to be insensitive to the ways in which young males may display and experience symptoms of distress or depression (Genuchi & Mitsunaga, 2015; Rice, Telford, Rickwood, & Parker, 2017). Over the last two decades, research has indicated that men's experience of depression can include externalising symptoms such as anger, substance use and risk-taking (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Rabinowitz & Cochran, 2008; Heifner, 1997; Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012) that fall outside the scope of current generic and gender neutral diagnostic criteria for depression. Indeed the salience of such

symptoms has been indicated by previous research linking aspects of externalising pathology and suicidality (Verona, Sachs-Ericsson, & Joiner, 2004; Ginley & Bagge, 2017).

Recent systematic reviews (e.g., Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016; Whittle et al. 2105) and epidemiological and meta-analytic studies provide support for consideration of externalising symptoms as part of the diagnostic profile of depression in men (Martin, Neighbors, & Griffith, 2013; Cavanagh et al., 2017). Further, longitudinal cohort research has suggested that a more inclusive conceptualisation and assessment approach may enable better identification of mental illness in at-risk individuals (Caspi et al., 2013). Following this, research exploring whether novel assessment tools may assist in the early identification of young men at risk for depression. One such self-report instrument is the Male Depression Risk Scale (MDRS-22; Rice, Fallon, Aucote, & Möller-Leimkühler, 2013), validated in general populations of Australian and Canadian men (Rice et al., In press) to assess broad externalising domains. While the MDRS-22 is being increasingly applied in clinical and research settings, large-scale studies are yet to report age differences for the six symptom domains. If externalising symptoms are indeed indicators of young men's distress it may be the case that tools assessing these symptoms (such as the MDRS-22) may have greater sensitivity in detecting suicide risk than existing depression measures.

The present study examined the associations that age and recent suicidal ideation have with externalising symptoms, beyond the influence of typical symptoms of depression as assessed by the PHQ-9 (Kroenke et al., 2001) depression scale. Given that young males are at greater risk of suicidality relative to older males, and are more likely to engage in risky and maladaptive behaviours, an age $\times$ recent suicidal ideation interaction was predicted to occur for the MDRS-22

subscales, and that these interactions would hold when controlling for internalising depression symptoms.

Method

Participants: Data was collected in April 2016 from a non-probability national sample of 1,000 Canadian men. Respondents were sourced from a Canadian online survey provider. Weighted randomization was used to select respondents with stratification quotas established to reflect national census data relative to age and region. Most respondents self-identified as heterosexual (90.2%), and worked full-time (52.0%), and a large proportion (44.1%) had a university undergraduate degree.

Measures: Internalising depression symptoms were assessed by the *Patient Health Questionnaire* (PHQ-9; Kroenke et al., 2001), a widely used self-report measure of the nine DSM-5 symptoms of depression over the preceding two week period where 0=‘not at all’ to 3=‘almost every day’. The internal consistency of the PHQ-9 was satisfactory ($\alpha=.92$) in the present sample. Externalising depression symptoms were assessed by the six subscales of the *Male Depression Risk Scale* (MDRS-22; Rice et al., 2013; 2017). Respondents rate items relative to the preceding month, where 0=‘not at all’ to 7=‘almost always’. Each of the subscales had satisfactory internal consistency in this sample; emotional suppression ($\alpha=.87$), drug use ($\alpha=.96$), alcohol use ($\alpha=.94$), anger and aggression ($\alpha=.93$), somatic symptoms ($\alpha=.87$), risk-taking ($\alpha=.83$). Recent suicidality was assessed using the binary yes/no item, “In the past month did you think about suicide?”

Procedure: Research ethics approval was granted by the University of British Columbia. The survey topic was not disclosed in the initial survey invitation, and only potential respondents

who went to the survey introduction page were advised that men's mental health was the focus. Respondents were reimbursed for their time with proprietary panel points, which could later be exchanged for various rewards.

Data analysis: Age categories were developed to reflect key developmental stages; emerging adult men (18-25 years), young adult men (26-35 years), middle adult men (36-50 years), older adult men (51-65 years) and retiree aged men (66+ years). One-way ANOVA examined differences in age across the groups, and independent *t*-tests evaluated PHQ-9 depression scores relative to recent suicidal ideation (yes/no). Two-way multiple analysis of covariance (MANCOVA) was undertaken using age category and recent history of suicidal ideation as between group factors, PHQ-9 depression, education (university degree yes/no) and employment (currently job-seeking yes/no) were covariates, and the six MDRS-22 subscales were dependent variables. Chi-square analyses were undertaken for the two younger groups based on cut-offs for PHQ-9 moderate depression (≥ 10) and MDRS-22 elevated (≥ 32) and high scores (≥ 51).

Results

Mean ages differed significantly across the five age groups $F(4, 995)=2864.36, p<.001, \eta^2=.920$), with all groups differing from one another (Bonferonni p 's $<.001$; see Table 1 for means and SDs). A significant association was observed between age and recent suicidal ideation, with emerging adult men (18-25 years) reporting a markedly higher frequency of recent ideation relative to the other age stratified cohorts $\chi^2(4, N=1,000)=39.68, p<.001$. Those reporting recent suicidal ideation tended to experience more severe internalising depression symptoms.

Insert Table 1 here

Consistent with our prediction, when controlling for internalising depression, education and employment status, significant MANCOVA effects were observed for age category $\eta^2 = .876$, $F(24, 3426) = 5.51$, $p < .001$, $\eta^2 = .032$; recent suicidal ideation $\eta^2 = .963$, $F(6, 982) = 6.21$, $p < .001$, $\eta^2 = .037$; and the age $\times$ recent ideation multivariate interaction $\eta^2 = .922$, $F(24, 3426) = 3.37$, $p < .001$, $\eta^2 = .020$ (significant covariates: PHQ-9 depression $p < .001$, $\eta^2 = .327$, employment $p = .005$, $\eta^2 = .019$). Figure 1 displays this interaction effect (including means and SDs). Higher MDRS-22 subscale scores were observed for emerging adult men (18-25 years) and young adult men (26-35 years) reporting recent suicidal ideation, relative to those without recent ideation, and to males in the other age categories.

Insert Figure 1 here

For each of the six MDRS-22 subscales at the univariate level, PHQ-9 depression scores were significant covariates (p 's $< .001$) though neither education nor employment status were significant univariate covariates. Main effects were observed relative to age (all six MDRS-22 subscales, p 's $< .002$), and main effects observed for recent ideation on the emotion suppression, drug use, and anger and aggression subscales (p 's $< .05$) with a trend-level association ($p = .05$) for risk-taking (see Table 2). In partial support of the hypothesis, significant age $\times$ recent ideation interactions were observed for drug use ($p < .001$), anger and aggression ($p = .026$), and risk taking ($p = .001$), and a nearly significant effect was observed for somatic symptoms.

Insert Table 2 here

For 18-25 year old and 26-25 year old males respectively, 27.3% ($n=12$, $\chi^2=5.35$, $p=.045$) and 31.4% ($n=43$, $\chi^2=20.17$, $p<.001$) of cases were detected by the MDRS-22 elevated cut-off but were unidentified by the PHQ-9, which decreased to 20.5% ($n=9$, $\chi^2=4.54$, $p=.067$) and 16.8% ($n=23$, $\chi^2=20.55$, $p<.001$) of cases when the MDRS high cut-off was used. A lower proportion of cases were unidentified by the MDRS-22 relative to the PHQ-9, respectively for 18-25 and 26-25 years by the MDRS-22 elevated cut-off; 6.8% ($n=3$), 4.4% ($n=6$), and the MDRS-22 high cut-off; 13.6 ($n=6$) and 11.7% ($n=16$).

Discussion

In the current study, young men (18-35 years) were more likely to experience recent suicidal ideation than were older men (>35 years), with ideation being associated with markedly higher scores on each of the six MDRS-22 domains. That this relationship held when controlling for internalising depression (as well as education and employment) suggests the potential importance of screening for men's maladaptive externalising symptoms rather than relying solely on measures consistent with generic or gender neutral current diagnostic criteria. The multivariate age $\times$ recent suicidal ideation interaction was consistent with the hypothesis, while at the univariate level, the interaction hypothesis was supported for the drug use, anger and aggression, and risk taking subscales, and with a nearly significant effect observed for somatic symptoms. These findings highlight the importance of these four domains for younger men regarding suicide risk. While the present data cannot determine causality and directionally of these relationships with suicide ideation, domains of drug use, anger and aggression, and risk taking are modifiable.

Assessment of, and subsequent intervention provided for these domains may assist to reduce the likelihood of young men's suicide risk.

The categorical analyses for younger men suggest that adopting an externalising symptom assessment tool such as the MDRS-22, may improve detection and facilitate early intervention for young males at risk of distress or suicide where between 16.8% and 31.4% of cases were uniquely identified by the MDRS-22 cut-offs. Nonetheless, as there were a proportion of cases unidentified by the MDRS-22 that were identified by the PHQ-9, adjunctive, rather than sole use, of the MDRS-22 appears indicated. The use of brief measures such as the MDRS-22, which largely focusses on behavioural symptoms, may provide a useful point of engagement and reference for some young men given indications that many in this population can experience challenges with affective awareness and emotional distress disclosure (Kealy, Ogrodniczuk, Rice, & Oliffe, in press). From a process viewpoint, the cumulative impact of prolonged difficulties such as childhood adversity, ongoing psychosocial stressors and substance misuse has been found to index suicide risk in young men (Cole, Protinsky, & Cross, 1992; Runeson, Beskow, & Waern, 1996).

Taking a developmental perspective, the influence of supportive environments (or lack thereof) during childhood and adolescence has been established as a salient factor in the development of internalising or externalising psychopathology for boys and adolescent males (Caspi et al., 2014; Galambos, Barker, & Almeida, 2003) and developmentally-sensitive interventions are recommended (i.e., Rice et al., 2016). A challenge for clinicians also is to recognise that while drug use, anger and aggression and risk taking in young men might be normed in terms of masculinity and many Western cultures, these actions may not be entirely

recreational or performative – but rather vital cues indicating high risk for depression, and by extension suicide.

The present study has notable strengths in drawing on a large representative Canadian sample, with findings holding after controlling for the effects of PHQ-9 depression scores. However, the data was cross-sectional, and prospective longitudinal studies are needed. Further, given data was self-report, recent suicidal ideation could not be verified at clinical interview. This study did not collect data on personality factors or relationship status, both of which are important factors in men's suicidality. Importantly, while there is a growing interest in the area of young men's mental health, the field must progress beyond description and measurement to develop and evaluate gender appropriate interventions to better enable young men to engage in and benefit from clinical services.

In summary, the present findings highlight the potential importance of screening for externalising symptoms, which appear to be potential markers of suicidality for young men. Further research is needed to determine temporal associations and prognostic utility of the MDRS-22. Given the increased risk of suicide in this population, there is a need to broadly implement assessment tools with greater sensitivity to factors possibly related to risk for suicide.

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Figure 1: Age $\times$ recent suicidal ideation effects for the MDRS-22 subscales (N=1,000)

Figure 1 JPEG.jpg

Table 1: PHQ-9 depression scores relative to recent suicidal ideation

	Age	No ideation n=849		Ideation n=151				
	M (SD)	% (n)	M (SD)	% (n)	M (SD)	<i>t, df</i>	<i>p</i>	<i>d</i>
18 – 25 years	22.00 (1.74)	59.1 (26)	7.88 (5.47)	40.9 (18)	14.83 (6.10)	3.96, 42	<.001	1.20
26 – 35 years	31.23 (2.83)	75.9 (104)	6.17 (5.04)	24.1 (33)	14.30 (6.92)	7.34, 135	<.001	1.26
36 – 50 years	43.24 (4.25)	88.3 (325)	4.86 (4.93)	11.7 (43)	12.26 (6.58)	8.85, 366	<.001	0.93
51 – 65 years	58.43 (4.36)	85.3 (250)	3.64 (4.33)	14.7 (43)	11.70 (6.60)	10.32, 291	<.001	1.21
66+ years	71.85 (4.78)	91.1 (144)	2.17 (2.76)	8.9 (14)	9.57 (6.07)	8.34, 156	.001	1.34
Total sample	49.63 (14.59)	84.8 (849)	4.30 (4.68)	15.1 (151)	12.60 (6.66)	18.70, 998	<.001	1.18

Table 2: Summary of follow-up univariate ANCOVAs for the six MDRS-22 subscales

Source	MDRS-22 Subscale	df	MS	<i>F</i>	<i>p</i>	η^2
PHQ-9 (covariate)	Emotion suppression	1	8617.47	247.64	<.001	.201
	Drug use	1	957.04	57.81	<.001	.055
	Alcohol use	1	2358.53	57.06	<.001	.055
	Anger & Aggression	1	6157.28	195.08	<.001	.165
	Somatic Symptoms	1	8240.03	327.29	<.001	.249
	Risk Taking	1	2247.57	173.26	<.001	.149
Education (covariate)	Emotion suppression	1	40.69	1.17	.280	.001
	Drug use	1	48.36	2.92	.088	.003
	Alcohol use	1	1.77	0.04	.836	.000
	Anger & Aggression	1	74.95	2.37	.124	.002
	Somatic Symptoms	1	23.33	0.93	.336	.001
	Risk Taking	1	2.07	0.16	.690	.000
Job seeking (covariate)	Emotion suppression	1	5.25	0.15	.698	.000
	Drug use	1	35.39	2.14	.144	.002
	Alcohol use	1	79.25	1.92	.166	.002
	Anger & Aggression	1	24.56	0.78	.378	.001
	Somatic Symptoms	1	42.67	1.70	.193	.002
	Risk Taking	1	26.92	2.08	.150	.002
Age	Emotion suppression	4	175.12	5.03	.001	.020
	Drug use	4	241.49	14.59	<.001	.056
	Alcohol use	4	201.40	4.87	.001	.019
	Anger & Aggression	4	190.60	6.04	<.001	.024
	Somatic Symptoms	4	232.25	9.23	<.001	.036
	Risk Taking	4	186.69	14.40	<.001	.055
Recent ideation	Emotion suppression	1	889.69	25.57	<.001	.025
	Drug use	1	132.57	8.01	.005	.008
	Alcohol use	1	4.58	0.11	.739	.000
	Anger & Aggression	1	338.56	10.73	.001	.011
	Somatic Symptoms	1	71.35	2.83	.093	.003
	Risk Taking	1	49.90	3.85	.050	.004
Age × Recent ideation	Emotion suppression	4	36.21	1.04	.385	.004
	Drug use	4	149.38	9.02	<.001	.035
	Alcohol use	4	74.96	1.81	.124	.007
	Anger & Aggression	4	87.79	2.78	.026	.011
	Somatic Symptoms	4	50.87	2.02	.090	.008
	Risk Taking	4	62.10	4.79	.001	.019

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Author/s:

Rice, SM;Kealy, D;Oliffe, JL;Ogrodniczuk, JS

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