

Men, suicide, and family and interpersonal violence: A mixed methods exploratory study

Scott J. Fitzpatrick^{1,2}  | Bronwyn K. Brew³ | Tonelle Handley² | David Perkins^{2,4}

¹Centre for Mental Health Research, The Australian National University, Canberra, Australia

²Centre for Rural and Remote Mental Health, The University of Newcastle, Orange, Australia

³National Perinatal Epidemiology and Statistics Unit, Centre for Big Data Research in Health and School of Women's and Children's Health, University of New South Wales, Sydney, Australia

⁴Health Research Institute, University of Canberra, Canberra, Australia

Correspondence

Scott J. Fitzpatrick, Centre for Mental Health Research, The Australian National University, 62 Mills Road, Acton, Australian Capital Territory, 2601, Australia.

Email: scott.fitzpatrick@anu.edu.au

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Abstract

Research has shown a link between gender, violence, and suicide. This relationship is complex, and few empirical studies have explored suicide and family and interpersonal violence perpetrated by men. Drawing on a coronial dataset of suicide cases and a mixed methods design, this study integrated a quantitative analysis of 155 suicide cases with a qualitative analysis of medico-legal reports from 32 cases. Findings showed different types and patterns of family and intimate partner violence for men who died by suicide. Men used violence in response to conflict, but also to dominate women. Cumulative, interwoven effects of violence, mental illness, alcohol and other drug use, socioeconomic, and psychosocial circumstances were observed in our study population. However, the use of violence and suicidal behaviour was also a deliberate and calculated response by which some men sought to maintain influence or control over women. Health and criminal justice interventions served as short-term responses to violence, mental illness, and suicidal behaviour, but were of limited assistance.

KEYWORDS

interpersonal violence, masculinity, men, rural health, suicide

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INTRODUCTION

The association between gender and suicide is evidenced by long-standing patterns that show men to have consistently higher rates of suicide than women in most Western countries (Cleary, 2019; Jordan & Chandler, 2019). The idea that men are especially vulnerable to suicide, however, should be understood in the context of operationalised definitions of suicidal behaviour that distinguish completed suicide from deliberate self-harm and attempted suicide—both of which are higher in women (Jordan & Chandler, 2019; Scourfield, 2005). Such claims also reflect relatively narrow, binary views of sex and gender (Cleary, 2019). A major criticism of the existing research on men and suicide is that scant attention is paid to issues of diversity and difference, with men viewed as a relatively homogenous category (Scourfield, 2005). Even within the masculinities literature, there is a tendency to conceptualise masculinity as a type, defined by traits such as stoicism, poor help-seeking, emotional inexpressiveness, and inadequate coping skills (Alston, 2012; Rasmussen et al., 2018). Moreover, the view that gender exerts the most powerful influence on attitudes and behaviour overlooks the role of other important factors such as age, class, or ethnicity (Morgan, 2006).

Causal reasoning in suicide research, coupled with the influence of survivor-guided advocacy on priority setting in suicide prevention, mean that men are almost exclusively regarded as victims of biological, psychological, and/or socioeconomic forces (Scourfield, 2005). Largely absent from these debates are the significant number of men who kill themselves in the context of longstanding, cumulative problems involving persistent alcohol and other drug (AOD) use, relationship conflict, and interpersonal violence. Often eliciting unsympathetic responses from families and services, their exclusion from the policy arena has led to the diminishing of important ethical and political questions of responsibility, choice, and agency in understanding men's suicide (Caine, 2013). It also reveals the plurality of suicidal men's emotional practices and the ways some men mobilise emotions of distress and anger in acts of violence and suicide (Chandler, 2019; River & Flood, 2021).

Research has shown that violent behaviour is an important risk factor for suicide regardless of psychiatric disorder or AOD use (O'Donnell et al., 2015; Stenbacka et al., 2012). The relationship between suicide, family, and intimate partner violence, however, is under-researched. A recent US study identified intimate partner violence in 43% of all suicide cases where circumstances relating to intimate partner problems were known (Brown & Seals, 2019), while a UK study of 100 suicide cases found almost one quarter displayed some aspects of domestic abuse (Scourfield et al., 2012).

STUDY AIMS AND METHODS

To address this research gap, this study aimed to explore the situational contexts of suicide and family and interpersonal violence perpetrated by men in rural Australia. This research uses a subset of data from a larger study of 3163 suicide cases in rural Australia investigating the multifactorial determinants of suicide (Fitzpatrick et al., 2021). Ethical approval for this study was granted by the Justice Human Research Ethics Committee of the Victorian Department of Justice and Community Safety and the University of Newcastle Human Research Ethics Committee.

Study design

Concerns over whether coronial data correspond with factual knowledge of individual suicides, or whether the need to establish intent leads to filtered accounts based on common sense assumptions about reasonable cause has prompted critical reflection on the contexts in which people engage in practical reasoning about suicide and the authority of descriptions (Atkinson, 1978; Fincham et al., 2011). For Fincham et al. (2011), the multiple, partial, and fragmentary accounts of suicidal individuals, family, friends, and, ultimately, police and coroners, mitigate against the possibility of a singular and coherent explanation of a suicidal event. This subjective dimension of inquest evidence does not diminish its validity; nor rule out the possibility that reasonably objective judgements about suicide can be reached. Rather, it requires researchers take seriously the way evidence is constructed, as well as the substance of the evidence in relation to the circumstances, beliefs, and actions of suicidal individuals. In seeking to explore the situational contexts of suicide and family and interpersonal violence, while also attending to the ways knowledge about suicide is produced, our study is influenced by the qualitatively driven, mixed methods sociological approach developed by Fincham et al. (2011).

Suicide data from the National Coronial Information System

This study is based on data on suicide deaths investigated by Australian coroners and transferred to the National Coronial Information System (NCIS) for storage and analyses. Deaths recorded in the NCIS with the International Classification of Diseases—Tenth Revision (ICD-10) code for intentional self-harm were interpreted as suicide (World Health Organization, 2016). NCIS data include case records that comprise basic demographic information (sex, birth year, post-code of usual residence, marital status, employment status, and occupation) and cause of death details (time, location, postcode of incident and death, and mechanism/object/substance causing injury).

The NCIS also holds supplementary non-coded data in the form of medico-legal reports (coroner's findings, autopsy, toxicology, and police reports) from the coronial investigation. Information in these reports is collected from health and police records, as well as from evidence provided by treating health or other professionals, family, and friends, including any suicide notes left by the deceased. Reports are text-only and attached to individual cases as a searchable PDF. Police reports and coroner's findings are in narrative form, while autopsy and toxicology reports follow a prescribed format in reporting results of tests performed. Institutional practices and legislative differences mean that the level of detail contained in these reports varies between and within each jurisdiction. While all cases have demographic data, not all have medico-legal reports as there are instances where certain procedures are not performed.

We acknowledge the situated nature in which people engage in practical reasoning about suicide (Atkinson, 1978; Mallon et al., 2016). In reconstructing the events that lead to suicide, police and coroners are concerned with establishing that the death is intentional and self-inflicted, and, as such, certain categories of evidence are required to build a tenable explanation (Atkinson, 1978). This information is not predetermined but requires coroners and police to

examine records and ask questions of medical professionals, next-of-kin, and available witnesses (Timmermans, 2005). Different modes of collecting, relating, and ordering this material meant that the type and amount of information included in medico-legal reports in this study varied considerably. Descriptions of very different kinds coexisted, with some police and coroners disposed towards compiling narratives of key life events and issues that appeared to have a profound impact on men. These stood in tension with reports that were limited to a description of the death scene and events immediately preceding the death. In the latter, reports focussed predominantly on well-known risk factors such as mental illness and relationship breakdown; a limitation noted by other researchers working with coronial data (Mallon et al., 2016).

Data collection

Data from 3163 closed cases of suicide of persons residing in rural Australia were extracted from the NCIS for the years 2010–2015. In recognition of the diversity of areas traditionally classified as ‘rural’, we collected data from four Australian states (New South Wales, Queensland, South Australia and Tasmania). Data were categorised by residential postcode using Australian Statistical Geography Standard Remoteness Area Codes. This divides rural Australia into four classes of remoteness according to population and distance to services: (1) Inner Regional Australia, (2) Outer Regional Australia, (3) Remote Australia, and (4) Very Remote Australia (Australian Bureau of Statistics, 2018).

Indicators of family and intimate partner violence, together with other health, socioeconomic, and psychosocial circumstances were obtained from quantitative coding of qualitative data in medico-legal reports and based on ICD-10 Codes with some modifications made to streamline data management (World Health Organization, 2016). Additional codes were developed with specific relevance to family and interpersonal violence such as contact with police and the issuing and violation of Domestic Violence Orders (DVO). For this study, we defined family and intimate partner violence as ‘acts of violence between family members as well as people who are in, or have been involved in, an intimate relationship. The violence may involve physical, sexual, financial, emotional or psychological abuse and include a range of controlling behaviours’ (Australian Medical Association, 2016, p. 1). Toxicology data were obtained from toxicology reports. Alcohol consumption before suicide was assumed if blood alcohol concentrations were ≥ 0.05 g/100 ml. This cut-off was selected because it is commonly used in the literature on alcohol use and suicide due to the adverse effects of alcohol on judgement, cognition, mood, and behaviour at and above this level (Chong et al., 2020).

In total, 155 suicide cases with family and intimate partner violence were identified. Each had basic demographic data, although data on marital and employment status were missing in 7%–14% of cases (Table 1). Most, but not all cases had medico-legal reports, and their quality varied with data on mental health, socioeconomic, and psychosocial circumstances incomplete or missing in some cases. It is not possible to tell whether information not recorded in medico-legal reports indicated an absence of enquiry by police and/or coroners or an unrecorded null finding. Human research ethics restrictions on the collection of data from Aboriginal and Torres Strait Islander peoples did not permit the inclusion of indigeneity in data analysis. In Australia, additional ethical requirements are needed to ensure the values and interests of Aboriginal and Torres Strait Islander peoples are supported, including Indigenous collaborators who were not available for this project.

TABLE 1 Demographic characteristics of men who died by suicide and perpetrated family and/or interpersonal violence 2010–2015 ($n = 155$)

	<i>n</i> (% of 155 cases)	Qualitative sample ($n = 32$)
Age (years)		
15–24	16 (10)	3
25–34	38 (25)	5
35–44	46 (30)	13
45–54	30 (19)	4
55–64	15 (10)	5
65 and over	10 (6)	2
Geographic location		
Inner regional	92 (59)	17
Outer regional	54 (35)	9
Remote and very remote	9 (6)	6
Marital status		
Married	63 (41)	11
Divorced/separated	51 (33)	12
Never married	26 (17)	5
Widowed	<5	0
Missing	11 (7)	4
Employment status		
Employed	74 (48)	12
Unemployed	45 (29)	12
Retired/Pensioner	12 (8)	3
Other	<5	0
Missing	21 (14)	5

A small sample of cases were selected for the qualitative analysis ($n = 32$). The sample included a case from each age cohort as well as from each of the four remoteness categories to satisfy a maximum variation strategy but based on quality of information provided in medico-legal reports. Quality was assessed as the completeness and comprehensiveness of the available data. The demographic characteristics of the qualitative sample are shown in Table 1.

Quantitative data analysis

Three researchers coded the available medico-legal reports for the entire study sample to develop a dataset of health, socioeconomic, and psychosocial variables combined with demographic data. For the 155 suicide cases with family and intimate partner violence reported in this study, factors including mental health status, use of health services, toxicology, socioeconomic, and psychosocial circumstances are reported as proportions. Analysis was performed using IBM SPSS Statistics 25. Due to high proportions of missing data in several key variables for the 155 cases (diagnosed mental illness, previous suicide attempt, expression of intent to self-harm, and

contact with health services), a multiple imputation analysis was conducted in the larger study sample of 3163 cases (Fitzpatrick et al., 2021). A fully conditional specification model was used, with 10 iterations to replace missing data for each of these variables. Each variable was imputed using age, sex, state, and marital status. Data for these variables are reported as both a complete case analysis and an imputed analysis (Sterne et al., 2009).

Qualitative data analysis

Analysis of medico-legal reports was conducted for the 32 cases selected for qualitative analysis using the Framework Method. This flexible analytic approach ensures interpretation remains grounded in the data while enabling synthesis of recurring patterns to build on existing theoretical understandings (Ritchie et al., 2005). Data coding, analysis, and interpretation involved a recursive and reflexive process that was systematic and analytic, yet oriented towards constant discovery and comparison of situations, settings, relationships, and meanings (Altheide et al., 2008). First, an inductive approach was applied whereby coding focussed on identifying recurring themes. This led to the construction of a coding scheme of descriptive categories for labelling and grouping the data that was applied to the 32 cases (Ritchie et al., 2005). Although analysis was inductive, reflecting evidence from medico-legal reports, our attention was also drawn to findings emerging from the statistical analysis, such as contact with police and expression of intent to self-harm. We then moved to more collective descriptive and explanatory analyses, introducing theoretical concepts and frameworks to generate explanations of family and intimate partner violence and suicide (Lewis & Ritchie, 2003). To ensure compliance with NCIS data reporting conditions, specific ages have been removed, pseudonyms allocated, and details from reports summarised rather than quoted directly to limit potential identification.

FINDINGS

Demographic characteristics

Table 1 describes the demographics for the whole cohort. Men who perpetrated family and interpersonal violence and who died by suicide were more likely to be younger at time of death than all male suicides in the general rural population. In our sample, more than half (54%) of suicide deaths were between the ages of 25–44, whereas in the general rural population this age group represented 35% of all male suicide deaths (Fitzpatrick et al., 2021). Additionally, only 7% of all suicide deaths in men who perpetrated family and interpersonal violence occurred in men aged 65 years and over compared to 19% of the general rural male suicide population (Fitzpatrick et al., 2021). Regarding marital status, 41% of men were married or in a cohabiting relationship, 33% were separated, and 17% were never married. Just under one-half of all men (48%) were employed and 29% unemployed.

The multidimensional nature of family and interpersonal violence in the context of suicide

Table 2 shows the different patterns of violence that were evident prior to suicide in various types of intimate relationships. The majority of cases involved violence against female partners or

TABLE 2 Patterns of violence across different types of intimate relationships ($n = 155$)

	<i>n</i> (%)
Relationship with the victim	
Current partner	64 (41)
Ex-partner	66 (43)
Family member(s)	25 (16)
Cohabiting with the victim	
Yes	48 (31)
No	105 (68)
Missing ^a	<5
Children in common with the victim	
Yes	73 (47)
No	46 (30)
Missing ^a	36 (23)
Child custody or support issue	
Yes	18 (12)
No	103 (66)
Missing ^a	34 (22)
Domestic violence order	
Yes	75 (48)
Violation of domestic violence order	24/75 (32)
No	72 (46)
Missing ^a	8 (5)

^a'Missing' indicates that either this information is unknown or that it is an unrecorded 'no' response.

ex-partners (84%). The remaining 16% of cases involved violence against other family members, most notably physical and emotional violence from sons towards parents and siblings, and sexual and physical violence from fathers towards female (step-) children. Approximately two-thirds of male offenders (68%) were not cohabiting with their female victims. DVOs were in place in 48% of cases with violations of DVOs having occurred in 32% of these cases.

Recognition of different types and patterns of family and intimate partner violence was also evident in our qualitative sample. For example, younger men directed their violence exclusively towards parents and siblings. These cases appeared rooted in familial conflict and marked by frequent bouts of verbal aggression and threats of harm. In his late teens, Adam experienced problems adapting to changing family and household dynamics following his parents' separation and relocation to a new town which led to ongoing conflict with his mother and increased drug use. Over a period of 18 months, he experienced a series of persistent struggles with police, school, juvenile justice, and mental health services as he sought to reduce his drug intake and transition into independent living without adequate financial, housing, or support systems in place. These struggles, and the resultant despondency, apathy, isolation, and anxiety that accompanied his attempts to change his life, were punctuated by intermittent explosions of anger and aggression.

In cases involving men's violence against female partners, it was not easy to detach family conflict from what the literature has described as intimate or patriarchal terrorism (Johnson, 1995;

Little, 2016). In his thirties, Stephen's divorce left him unable to negotiate access to his children and in significant debt. Distressed and frustrated, reports described a series of unfolding and layered events: an abandoned suicide attempt, a court hearing, the accrual of personal debts, a physical dispute with his ex-wife's new partner, the issuing of a DVO, and, finally, his suicide.

In a majority of cases, physical violence was reported less than other forms of emotional and psychological controlling behaviour such as damaging property, brandishing weapons, and threatening force or self-harm. As well as the harms it caused to women, this violence was often associated with a range of negative outcomes for men, including incidences of depression, stress, and anxiety. In the case of Robert, family and friends reported a marked deterioration in mental health and marital relations in the weeks before his suicide following an incident where he threatened his partner with a weapon. Feelings of shame may have contributed to Robert's sense of isolation or separateness from his partner and escalated feelings of distress and suicidality (Chandler, 2021; Olliffe et al., 2016).

Violence and suicide as situated conduct

Violence is often viewed as a function of psychopathology (Pain, 2015), and research has shown an association between heavy episodic drinking, drug use, and intimate partner violence (Gilchrist et al., 2015; Hearn et al., 2013). Given the focus of medico-legal reports on men's emotional state, a diagnosed mental illness was reported in 39% of cases ($n = 60$) with mood disorders the most common diagnosis (82%, Table 3). It is likely that mental illness diagnoses were under-reported since more than half the relevant reports were missing data in this category. When missing data were imputed, this number increased, with 79% of cases estimated as having a diagnosis. A diagnosed substance use disorder was reported in only 7% of all cases. However, problems related to AOD dependency were reported in 30% of all cases (Table 3). Furthermore, toxicology reports showed that approximately 60% of cases had a blood alcohol reading of ≥ 0.05 g/100 ml or evidence of drug use (Table 3).

The relationship between mental illness, AOD use, violence, and suicide is complex (O'Donnell et al., 2015; Varshney et al., 2016). Cross-tabulation of diagnosed mental illness with socioeconomic and psychosocial circumstances showed that while 23% of cases had a single reported circumstance, the majority of cases (73%) reported two or more circumstances (Table 4). Criminal justice issues were the most commonly reported circumstance (65%), in combination with mental health problems (27%), family disruption following divorce or separation (25%) or employment/unemployment issues (25%; Table 4). Viewing men's violence as situated conduct grounded in a complex interplay of factors shifts focus from individual internal processes to the cumulative, interwoven effects of mental illness and AOD use on men's violence, the social contexts in which it occurred, its gendered nature, and the intended outcomes of offender's actions (Cannon et al., 2015).

Some caution, therefore, is needed not to confuse men's individual and social circumstances with their decision to use violence, or to minimise men's responsibility for their actions (Pease, 2012). While cases revealed the fragility of masculine identity in the face of potential threats, the use of violence and suicide by men in the study was almost always a deliberate and calculated response to those threats. Take, for example, the case of Greg. Some years off retirement, Greg had difficulty getting work due to a chronic health condition and ageist practices in the labour market. Growing financial and housing insecurity further fuelled his disaffection and coupled with marital problems, led to two incidents of violence towards his wife. These

TABLE 3 Suicidal behaviour, mental health, socioeconomic, and psychosocial circumstances ($n = 155$)

	<i>n</i> (%)
Mental illness diagnosis	
At least one diagnosis	60 (39)
Mood disorder	49/60 (82)
Substance use disorder	11/60 (18)
Other	14/60 (23)
No diagnosis	24 (15)
Missing ^a	71 (46)
Previous suicide attempt	
Yes	38 (25)
No	12 (8)
Missing ^a	105 (68)
Prior expression of intent to self-harm	
Yes	64 (41)
No	21 (14)
Missing ^a	70 (45)
Alcohol and other drug use	
At least one substance	94 (61)
Alcohol (≥ 0.05 g/100 ml)	58 (37)
Cannabis	32 (21)
Opioids	18 (12)
Methamphetamine	17 (11)
None present	49 (32)
Missing ^a	12 (8)
Socioeconomic and psychosocial circumstances	
Problems related to criminal justice	100 (65)
Family and intimate partner violence	75 (48)
Charges or conviction in other civil or criminal proceedings/problems related to incarceration	35 (23)
Problems related to employment/unemployment	52 (34)
Disruption of family by separation/divorce	50 (32)
Problems related to alcohol and/or other drug dependency	47 (30)
Problems related to housing and economic factors	20 (13)
Problems related to upbringing	12 (8)
Recent death of a family member or friend	12 (8)
Problems related to social environment	11 (7)
Other	3 (2)
No socioeconomic or psychosocial circumstances	2 (1)

^a'Missing' indicates that either this information is unknown or that it is an unrecorded 'no' response.

TABLE 4 Cross-tabulation of mental health, socioeconomic, and psychosocial circumstances (*n* = 155)

	Problems related to criminal justice <i>n</i> (%)	Problems related to employment and unemployment <i>n</i> (%)	Disruption of family by separation or divorce <i>n</i> (%)	Problems related to alcohol and other drug dependency <i>n</i> (%)	Problems related to housing and economic factors <i>n</i> (%)	Mental illness <i>n</i> (%)
Problems related to criminal justice	19 (12) ^a					
Problems related to employment and unemployment	38 (25)	5 (3) ^a				
Disruption of family by separation or divorce	38 (25)	14 (9)	5 (3) ^a			
Problems related to alcohol and other drug dependency	34 (22)	26 (17)	31 (20)	5 (3) ^a		
Problems related to housing and economic factors	13 (8)	15 (10)	7 (5)	6 (4)	<5 ^a	
Mental illness	42 (27)	24 (15)	22 (14)	24 (15)	7 (5)	NA ^a

^aRepresents cases that reported a single circumstance.

culminated in police involvement and the eventual breakdown of his marriage a few days before his suicide. His last contact with his wife was an accusatory telephone call.

This web of interdependent health, socioeconomic, and psychosocial circumstances created a complex emotional environment in which men appeared to express a number of contradictory feelings: dependence, intimacy, fear of abandonment, love, disappointment, and the need to control a relationship they felt they were losing (Borochowitz & Eisikovits, 2002). In the case of Trent, intimacy occurred ‘within, and even as, violence’ (Hearn, 2012, p. 155). In response to their marriage troubles and pending separation, Trent and his partner had sought relationship counselling. Believing herself to be subject to ongoing coercion and manipulation, Trent’s partner decided to stop attending the counselling sessions. On hearing this, Trent threatened to stop paying child support. This ‘paradoxical convergence of violence and “intimacy”’ (Hearn, 2012, p. 155) was perhaps most evident in the case of Mark, whose romantic love and idealisation of his partner existed almost simultaneously with feelings of jealousy, possessiveness, anger, hatred, and an unrelenting insistence on obedience and respect (Borochowitz & Eisikovits, 2002; Dekeseredy et al., 2007). Catalysed by methamphetamine use, Mark’s violence towards his partner was confrontational, unrestrained, severe, and followed immediately by feelings of regret, blame, and self-justification.

A quarter of cases had made a previous suicide attempt and 41% had a prior expression of suicidal intent (Table 3). When missing data was imputed these rates become closer to 75% and 73% respectively. Qualitative data showed that threats of self-harm were a common tactic of coercive control used by men to instil fear and exert power, predominantly in the context of divorce and custody battles. In the case of Ian, reports described a long history of controlling and abusive behaviour towards his wife and two separate threats of suicide. First, after the relationship

deteriorated following his wife's return after a brief separation; and second, after she told him she intended separating from him permanently. Ben, a known drug-user who had been suffering from drug-induced psychosis threatened self-harm if his partner ended their relationship. These threats were followed by a series of taunting text messages in which he demanded she come back to him or else he would kill himself. Threats of self-harm were also brutal acts aimed to cause emotional and psychological distress. Jeff threatened to kill himself in front of his partner following an argument until police arrived and intervened. Non-verbal threats were also present with three cases involving men fashioning nooses which they showed to their partners or left lying around the house. In several cases, suicide threats were so commonplace that partners no longer treated them as serious.

The qualitative data also showed that, in some cases, suicide was intended as a form of punishment for women; a decisive violent act that was both psychosocial in means and effects (Hacking, 2008; Scourfield, 2005; Scourfield et al., 2012). In response to Ben's text messages, his partner called back immediately, and, when there was no answer, drove to his house only to find he had already killed himself. In two other cases, damaged personal items and spiteful messages were left at the scene. In these cases, the act of suicide was directed towards specific ends, whether to punish, exact revenge, or lay blame and guilt upon partners who men believed had hurt or deserted them. In these cases, violence and suicide revealed the dynamics of men's power, but also their powerlessness.

Health and criminal justice interventions

Health service data were available for 47% of cases (Table 5). In the 6 weeks before suicide, 24% ($n = 37$) of all cases had visited a health service at least once (Table 5). A further 16% ($n = 24$) had visited a health service in the weeks and months before suicide, but no dates were recorded; hence it is possible that rates of service visits in the 6 weeks before suicide were under-reported.

TABLE 5 Contact with health services and/or police in the six weeks before suicide $n = 155$

	<i>n</i> (%)
Health service visits in the 6 weeks before suicide	
At least one visit	37 (24)
At least two visits	14 (9)
Total visits (including multiple visits by one person)	59 (38)
Mental health or alcohol and other drug services	24/59 (41)
Emergency department	16/59 (27)
Primary care	12/59 (20)
Tertiary care (non-mental health)	7/59 (12)
No	36 (23)
Missing ^a	82 (53)
Contact with police in the 6 weeks before suicide	
Yes	74 (48)
No	58 (37)
Missing ^a	23 (15)

^aMissing^a indicates that either this information is unknown or that it is an unrecorded 'no' response.

The imputed data support these findings, estimating that 53% of men visited a health service at least once in the 6 weeks before suicide. Of all health service visits, 41% were to mental health or AOD services, 27% were to an emergency department, and 20% to a primary care provider (Table 4). In the 6 weeks before suicide, almost half ($n = 74$) of men had been in contact with police (Table 5).

Coroner's findings and police reports showed that in health settings, violence (including the threat of suicide) was primarily attributed by health professionals to a transient situational or emotional crisis in which mental illness and/or AOD use were important contributory factors. Consequently, treatment focussed on management of these crises, primarily using medication, with a tendency to downplay violent behaviour (Domestic Violence Prevention Council, 2016). There was little evidence for the effectiveness of health service interventions, with coroner's findings identifying several problems in risk assessment, patient discharge, follow-up, and support. In the case of Trent, specific details and arrangements for ongoing care were not confirmed, and there was no communication between tertiary and primary care services upon discharge. The lack of a structured referral process meant that Trent could not access social support for identified financial and relationship stressors.

For Anton, who was experiencing several adverse psychosocial factors in combination with comorbid mental health and substance use issues, hospitalisation provided a level of respite from reported panic attacks, insomnia, substance use, psychotic symptoms, and thoughts of self-harm. However, hospitalisation was also reported as counter-therapeutic as it provided a short-term solution and resulted in a negative experience of care. Upon discharge, Anton stated a preference for a long-term outpatient programme that would address his drug use and underlying psychosocial issues; something that his treating psychiatrist reported could be achieved better in the private sector. With service interactions providing important opportunities for intervening to prevent further violence, including suicide, Anton's case revealed important shortcomings in public mental health service's capacity to manage the hospital to community care transition, as well as ongoing issues integrating mental health, AOD, and social services, including offender programs or interventions.

The complex gatekeeping role played by police in managing incidents of violence and self-harm was evident in the policing of men in crisis. As primary responders to family and intimate partner violence and mental health crises, police make important decisions about whether the criminal justice or mental health systems are the most appropriate pathway (Morgan, 2021). In cases where physical violence, property damage, or another criminal offence occurred, including violation of a DVO, men were charged with a criminal offence. However, in cases involving previous or current expressions of suicidal behaviour, police invariably chose a health system pathway despite some men displaying anger, agitation, unpredictability, and aggression. Bryce, for example, came to the attention of police in the weeks before his suicide when he refused their assistance following a welfare check made after he had threatened suicide. One week later, police visited Bryce's home following further concerns for his welfare. In this instance, he locked himself inside the house, damaged property, and made threats of violence towards police, including threatening to provoke the police to use lethal force if they did not leave. During this time, he also sent harassing text messages to his ex-partner. Eventually, police were able to negotiate with him to attend hospital for an Emergency Examination Order (EEO) where he was admitted as an inpatient. His ex-partner subsequently applied for a DVO. He was discharged several days later with appropriate medication and follow-up procedures, but when police were called due to renewed concerns about his welfare, he was found dead.

Coroner's findings and police reports showed that the issuing of DVOs by police caused considerable distress to some men. For Tony, who had actively participated in counselling sessions following his recent separation in a bid to save his marriage, surprise and shock were reportedly most pronounced. Similarly, for Christopher, the issuing of a DVO appeared to be the latest in a series of events that marked the slow and painful unravelling of his marriage and family, with the court order prohibiting him from having any further contact with his former partner and children. Despite police involvement, it appeared that none of the men in the qualitative sample received specific treatment or programs to address their violent behaviour.

DISCUSSION

Various forms and patterns of family and intimate partner violence were found in the study. This included physical, sexual, psychological, threatening, coercive, and economically abusive behaviour. In most cases, violence was part of a longer-term pattern rather than a one-off event (State of Victoria, 2016), although this pattern did not always involve an escalation of violence. Assumptions about the inevitability of escalation in cases of intimate partner violence may obscure the complexity of the problem (Corvo & Johnson, 2003). In particular, the way that escalation may manifest itself as self-destructive violence rather than as direct violence against others.

Findings from the study help to contextualise the relationship between mood symptomatology, socioeconomic and psychosocial circumstances, interpersonal factors, violence and suicide. This provides a more sophisticated picture of the high prevalence of mental illness diagnoses reported in the study that might otherwise be lost when mental illness is understood in isolation from its social contexts (Mallon et al., 2016). Unemployment and divorce can threaten men's roles and social identities and lead to symptoms of depression (OliFFE et al., 2012). It also suggests that short term mental health and criminal justice interventions may be insufficient to effect substantive behavioural and personal change in men. Notwithstanding the fact that the symptomatology of mental illness and/or AOD use may contribute to conflictive or distressing situations, there is a clear need for interventions that address employment security in rural areas, and that provide access to well-resourced, targeted, integrated health and community services and perpetrator programs (Chandler, 2021; Domestic Violence Prevention Council, 2016).

The use of violence and suicide by men in the study largely took place in the context of breakdowns in heterosexual relations. Heteronormative ideals around marriage, family, authority, and the appropriation of women's bodies were implicit in the experiences, expectations, emotions, and actions of men who suddenly found intimate partners out of reach (Chandler, 2019; Yep, 2003). Men's actions appeared to be predicated on the anticipation that the systematic use of violence, threats, economic subordination, or other tactics would exert psychological control over intimate partners and lead to changes in their behaviour (Coates & Wade, 2004; Pain, 2014). When those changes did not occur, suicide became a final act aimed at inflicting guilt and retribution on (ex) partners. In contrast, in a small number of cases where violence was perpetrated against other family members such as parents or siblings, or where men were already separated/divorced, problems related to unemployment, housing, financial issues, and legal circumstances appeared as more important precipitants of suicide. In these cases, men's experiences of power and powerlessness were evident as access to men's traditional privileges seemingly offered few rewards, and men descended into a cycle of indifference, despair, violence, and death (Hall, 2002).

Men's suicidal actions and their accompanying discourses are staging points for asserting or challenging gender, class, identity, and power concerns (Widger, 2012). This helps us

to contextualise men's suicide within interpersonal, structural and social relations, but also to consider certain claims and counterclaims about suicide as a socially meaningful act. The idea of a dominant (white) masculinity as being in crisis, with suicide a hypothesised symptom, has been criticised for overlooking the fact that macro-level social and economic changes impact women as well as men, and people of colour more than whites (Morgan, 2006; Robinson, 2000). This should not diminish the value of the concept of crisis in helping us to understand the magnification and intensification of events in which men perceived their lives to be unravelling, and that became occasions for suicide (Caputo, 1993). But caution should be exercised in generalising from the experiences of some men to the population as a whole. While representations of wounded men were palpable in medico-legal reports where men displayed evidence of disempowered masculinity and the desire to harness emotions of pain, aggrievement, frustration, distress, and rage to enact violence against themselves and others (Robinson, 2000), the extent to which suicide functioned as an expression of men's power needs to be considered. Previous research has indicated that men mobilise emotions in acts of abuse and violence, and that suicide is not only a reaction to emotional distress, but that it may also operate as distinct form of violence aimed at punishing others (River & Flood, 2021; Scourfield et al., 2012). Therefore, there is a need to consider how dominant narratives about disempowered masculinity may have shaped the way evidence from various actors was presented in medico-legal reports (Langer et al., 2008). As Robinson (2000) has suggested, the therapeutic discourse of individual men's experiences of emotional pain and distress is emblematic of wounded and disempowered masculinity, at the same time as this focus on men's bodies conceals the social, institutional, and political supports of men's violence.

The dynamics, severity, and impacts of suicide and how it can be used to communicate a particular set of meanings has been well documented by those studying the social meanings of suicide (Douglas, 1967; Staples & Widger, 2012). Because the act of suicide draws on culturally established meanings and is a practice for expressing emotion, agency in suicide is both gendered and relational (Jaworski, 2010; River & Flood, 2021). The social and moral potency of suicidal acts performed by some men in our study are therefore important for considering how men used suicide as a form of indirect power over others with intentional, damaging, and long-term effects (Counts, 1984). Suicide operates as a form of indirect power over others because of judgements of responsibility on those who may be seen to have 'caused' the death (Douglas, 1967). This can lead to feelings of blameworthiness and guilt on the part of survivors. The grief and guilt associated with suicide can be especially pernicious and disruptive to relationships within families, including those between mothers and their children (McMenamy et al., 2008). Suicide, therefore, can be viewed in terms of a tactic or strategy by which some men sought to maintain influence or control over women, even in death (Chandler, 2019; Counts, 1984). Viewed as such, suicide may reinforce relations of power, and make it a compelling option for some men.

LIMITATIONS

In cases of incomplete or missing data, there was a risk of bias in the quantitative analysis. However, multiple imputations of these variables found that rates were similar to those excluding missing data, increasing confidence in the results. The focus of medico-legal reports on proximal factors meant that information on distal factors such as family history or experiences of childhood adversity/violence was limited in many cases. The sampling of medico-legal reports for qualitative analysis based on the quality of data may have also resulted in the exclusion of some individuals or groups unlikely to be represented, such as the socially isolated or marginal-

ised. A product of the coronial investigation, informants' narratives involve retrospective interpretation and reporting on the deceased's thoughts, emotions, and behaviours. As such, they are necessarily partial, subjective, and both constituting and constituted by particular contexts (Bantjes & Swartz, 2019). While medico-legal reports are a rich source of data, we acknowledge the contexts in which people engage in practical reasoning about suicide and the problematic authority of these accounts (Scourfield et al., 2012).

CONCLUSION

This study contributes to our understanding of gender, violence, and suicide, highlighting the socio-demographic and situational factors in which family and intimate partner violence and suicide occurs, and the intended outcomes of men's actions. Health, socioeconomic, and psychosocial circumstances created a complex emotional environment in which men enacted different forms of violence as a means of exerting control over specific situations and intimate others. This resulted in a variety of negative outcomes for women and family members, but also for men. The proportion of men in contact with police and/or health services in the weeks before suicide was high. However, health and criminal justice interventions served as short-term responses to violence, mental illness, and suicidal behaviour, were disjointed, and did not directly communicate with each other. The study highlights the need for interventions that address employment security in rural areas, and that provide access to well-targeted, integrated health and community services and perpetrator programs.

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AUTHOR CONTRIBUTION

Scott J. Fitzpatrick: Conceptualisation (lead); Data Curation (lead), Formal Analysis (equal); Investigation (equal); Methodology (lead); Project Administration (lead); Supervision (lead); Writing – Original Draft Presentation (lead); Writing – Review and Editing (lead). **Bronwyn K. Brew:** Data Curation (supporting), Formal Analysis (equal); Investigation (equal); Methodology (supporting); Writing – Original Draft Presentation (supporting); Writing – Review and Editing (supporting). **Tonelle Handley:** Formal Analysis (supporting); Investigation (supporting); Writing – Original Draft Presentation (supporting); Writing – Review and Editing (supporting). **David Perkins:** Writing – Original Draft Presentation (supporting); Writing – Review and Editing (supporting).

DATA AVAILABILITY STATEMENT

Ethical restrictions apply to the sharing of the de-identified dataset used in this study as it contains potentially identifying or sensitive information, and was used under licence from the National Coronial Information System and the Justice Human Research Ethics Committee. Data are available upon request and with permission of the: National Coronial Information System, GPO Box 123, Melbourne, VIC 3001 ncis@ncis.org.au; Victorian Department of Justice and Community Safety, GPO Box 4356, Melbourne, VIC 3001 ethics@justice.vic.gov.au.

ORCID

Scott J. Fitzpatrick  <https://orcid.org/0000-0002-6171-0132>

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