**Suicide prevention targeting middle-aged males: the role of primary care**

Wetherall and O’Connor¹ consider the Mughal et al national case study series' looking at antecedents to suicide in middle-aged males, and in particular the role of primary care:

‘Mughal and colleagues conducted a national case series study to establish antecedents to suicide in middle-aged males who had consulted a GP before dying by suicide ... they found that two-fifths (43%) had consulted a GP in the previous 3 months, with more than half reporting a mental health problem. Further, males who had recently consulted their GP were more likely to report a physical illness, recent history of self-harm, a mental health problem. Further, males who had recently consulted their GP were more likely to report a physical illness, recent history of self-harm, a mental health problem, and in particular, the role of primary care:

The authors suggest that GPs should be vigilant to the potential for suicide risk when these factors present themselves in middle-aged male patients.¹

Wetherall and O’Connor offer two models to better conceptualise how various factors operate to increase suicide risk. Figure 1 is of particular interest, with its 3-stage model of ‘suicidal behaviour’.¹

Surely there is an urgent need to focus on the ‘pre-motivational phase’ in order to ensure that fewer people ever proceed to the higher-risk ‘motivational’ phase?

People are routinely being prescribed drugs such as antidepressants when they are experiencing stressful life events and/or adverse environmental conditions (that is, ‘pre-motivational background factors and triggering events’) – and serious ‘side effects’ and withdrawal effects of antidepressants have been seriously overlooked. The common antidepressant ‘side effects’ (sexual dysfunction, emotional numbing, excess introspection, fatigue, gastrointestinal problems, etc.) surely contribute to the ‘motivational’ factors clearly shown in the model. Adverse effects such as medication-induced akathisia can also occur - and are too often misdiagnosed, with tragic consequences (https://misssd.co, the Medication-Induced Suicide Prevention and Education Foundation in Memory of Stewart Dolin [MISSD] – akathisia support).

The recent BBC Panorama programme ‘The Antidepressant Story’³,⁴ explored this and raised awareness of previously underplayed and sometimes lasting sexual effects of commonly GP-prescribed antidepressants. These included post-selective serotonin reuptake inhibitor (SSRI) sexual dysfunction and post-SSRI sexual dysfunction (PSSD) (underreported due to its embarrassing and personal nature).³ These prescribed drug effects have huge consequences for people and their relationships – and especially middle-aged men who may well find themselves experiencing the full range of ‘motivational factors’ identified in the O’Connor and Kirtley model in Figure 1.¹

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**References**


DOI: https://doi.org/10.3399/bjp23x734733

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**Generating gender generalists**

Many points resonated with me when I read Saul Miller’s article.¹ I am a female GP trainee and I don’t know how to communicate with the male species. Is it any wonder, when on a standard day last week, 77% of my adult appointments were with women?²

I would even take the argument further and suggest that it’s difficult as a female practitioner to see any male patient. Our triage team have booking rights over our appointment slots to place patients where they deem to be most suitable. This means my slots are often filled with women and a self-perpetuating cycle ensues. Our triage system means we have removed the choice from our patients and assumes they would want to see a practitioner of the same gender. Of course, we all have a tendency towards homophily, but we will never be able to perfectly match our population’s demographics. Perhaps a move towards consulting with artificial intelligence will eliminate the propensity of male patients seeking males GPs? Or maybe it will just amplify existing sociocultural discriminations?² Another solution could be to anonymise gender from our computer systems; however, this has huge implications for screening and the way we manage risk for patients with diseases that are sex linked.

By only seeing women, I feel that I am not becoming a well-rounded GP. Does it matter? I’ll be hopeless at guiding future (male) GPs through men’s health concerns but, if nothing changes, my patient gender balance will likely persist once I qualify. It would be futile for me to learn how to do a hip replacement; is the same true for talking to men?

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**References**