



**18th Canadian Collaborative
Mental Health Care Conference (2017)**

Connecting People in Need with Care

June 2 and 3, 2017 | Delta City Centre, Ottawa, Ontario

***Suicide Prevention Among Men: Innovative
Interventions with a High-Risk Demographic***
Marnin J. Heisel & Simon Hatcher

PRESENTER DISCLOSURE

- **Presenter:** Dr. Marnin J. Heisel, Ph.D., C.Psych.
Department of Psychiatry, The University of Western Ontario (UWO)
- **Relationships with commercial interests:**
 - **Grants/Research Support:** N/A
 - **Speakers Bureau/Honoraria:** N/A
 - **Consulting Fees:** N/A
 - **Other:** I currently hold grant funding as PI from Movember Canada and from the Lawson Health Research Institute, and as co-PI or co-I from OSSU, CIHR, CFN, and UWO but have no commercial interests/conflicts with any of these. I was an unpaid member of the advisory group for a guideline by the Suicide Prevention Resource Center that will be mentioned in today's presentation. I received travel and stipend support to serve as an expert participant at a Canadian military and veteran's suicide prevention meeting. I am receiving a stipend for reviewing project grants for the U.S. Military Suicide Research Consortium.



**18th Canadian Collaborative
Mental Health Care Conference (2017)**
Connecting People in Need with Care
June 2 and 3, 2017 | Delta City Centre, Ottawa, Ontario



Bureau du développement
professionnel continu
Office of Continuing
Professional Development



MITIGATING POTENTIAL BIAS

- **Presenter: Dr. Marnin J. Heisel, Ph.D., C.Psych.**
- **Mitigation of conflict:** I have no conflicts to declare; however, will strive to present a balanced and unbiased presentation and to openly address differences of opinion in the empirical literature, where present



**18th Canadian Collaborative
Mental Health Care Conference (2017)**
Connecting People in Need with Care
June 2 and 3, 2017 | Delta City Centre, Ottawa, Ontario



Bureau du développement
professionnel continu
Office of Continuing
Professional Development



LEARNING OBJECTIVES

- 1. Identify demographic and psychosocial factors that contribute to elevated suicide risk among men;**
- 2. Describe challenges and opportunities inherent in engaging men in targeted suicide prevention interventions;**
- 3. Discuss innovative Canadian research studies currently underway designed to address the needs of men at-risk for suicide.**



**18th Canadian Collaborative
Mental Health Care Conference (2017)**
Connecting People in Need with Care
June 2 and 3, 2017 | Delta City Centre, Ottawa, Ontario



Bureau du développement
professionnel continu
Office of Continuing
Professional Development



The Epidemiology of Suicide

- The WHO (2014) estimates that roughly 800,000 lives are lost to suicide worldwide, every year (2% of all deaths).
- This exceeds the number of lives lost to war and homicide combined.
- The costs of suicide are staggering, exceeding \$2 Billion annually in Canada alone.
- In Canada, more people died by suicide in 2013 (4,054) than transport accidents (2,460), homicide (446), and HIV (189) **combined** (3,095 total)
- Unlike suicide, the prevalence of these other causes of death are declining in this country

- Although suicide risk is elevated in certain groups (including individuals with severe psychopathology, histories of self-harm, etc.), suicide affects people of ALL social classes, religions, cultures, ethnicities, and nations of origin, but does so unequally and inequitably

- Older men have the highest rates of suicide globally; middle-aged men account for the highest number of deaths by suicide in North America

- The WHO (2014) report “Preventing Suicide: A Global Imperative” notes:

“In richer countries, three times as many men die of suicide than women do, but in low- and middle-income countries, the male-to-female ratio is much lower at 1.5 men to each woman.”

- Women have higher suicide rates than men in China, largely due to high rates of pesticide self-poisoning among young rural women

A black and white photograph of two hands reaching towards each other, one from the top right and one from the bottom left, set against a light grey background. The hands are positioned as if they are about to meet or are in a gesture of support. The entire image is framed by a thick red border.

Preventing suicide

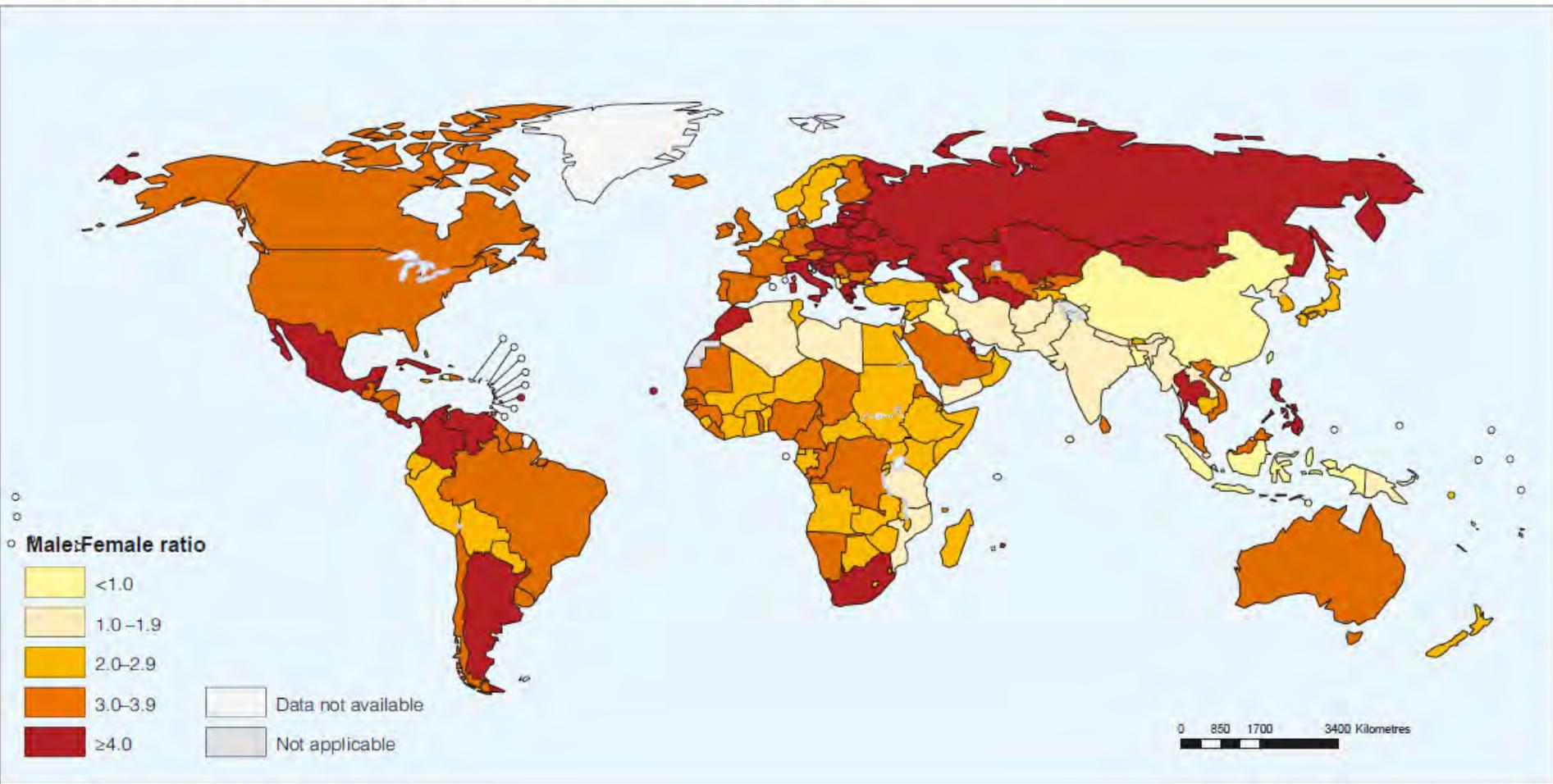
A global imperative



World Health
Organization

- The standardized global suicide rate is 11.4/100,000 for both sexes, or 15.0 for men and 8.0 for women, yielding a 1.9 M:F ratio for global deaths by suicide

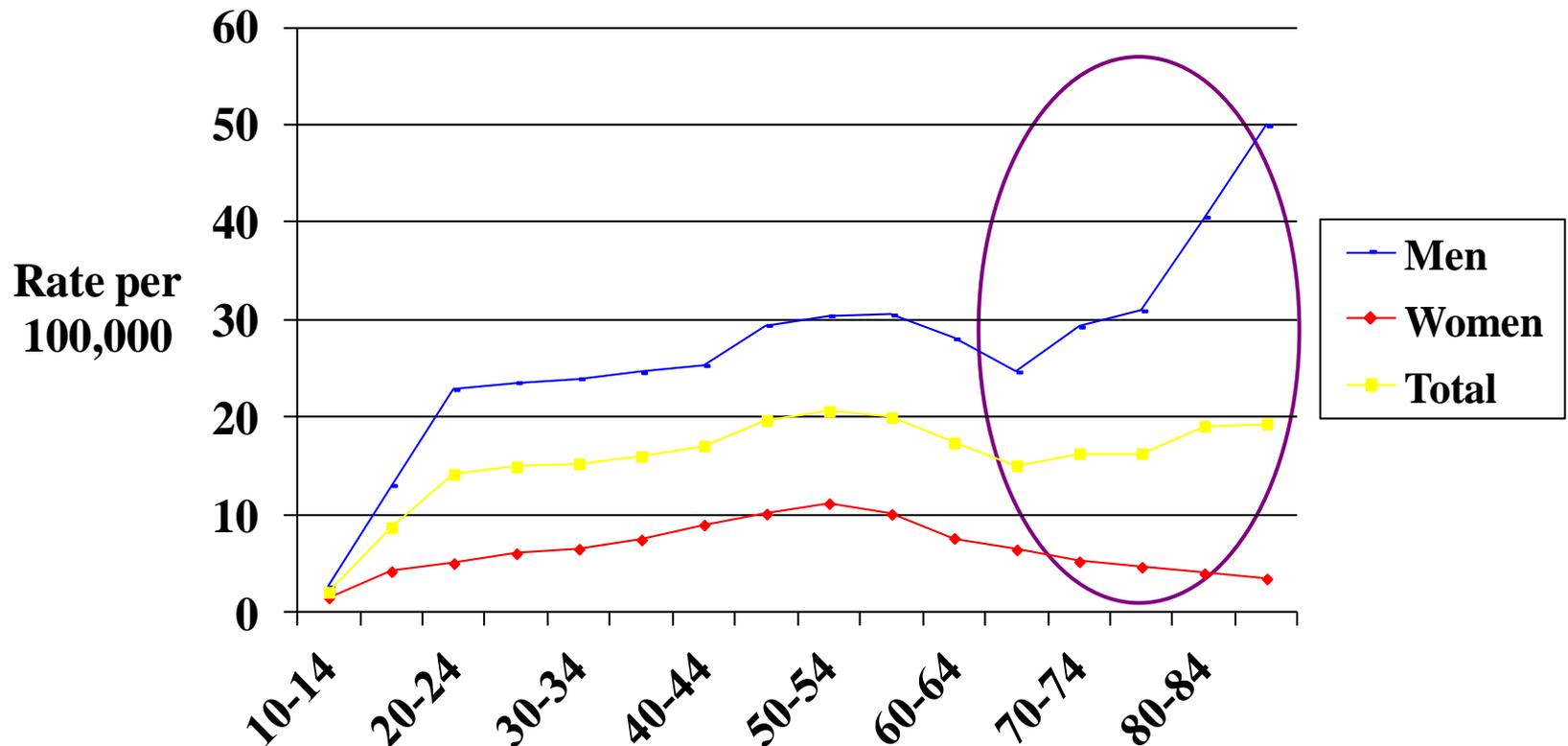
Map 3. Male:Female ratio of age-standardized suicide rates, 2012



Source: WHO (2014)

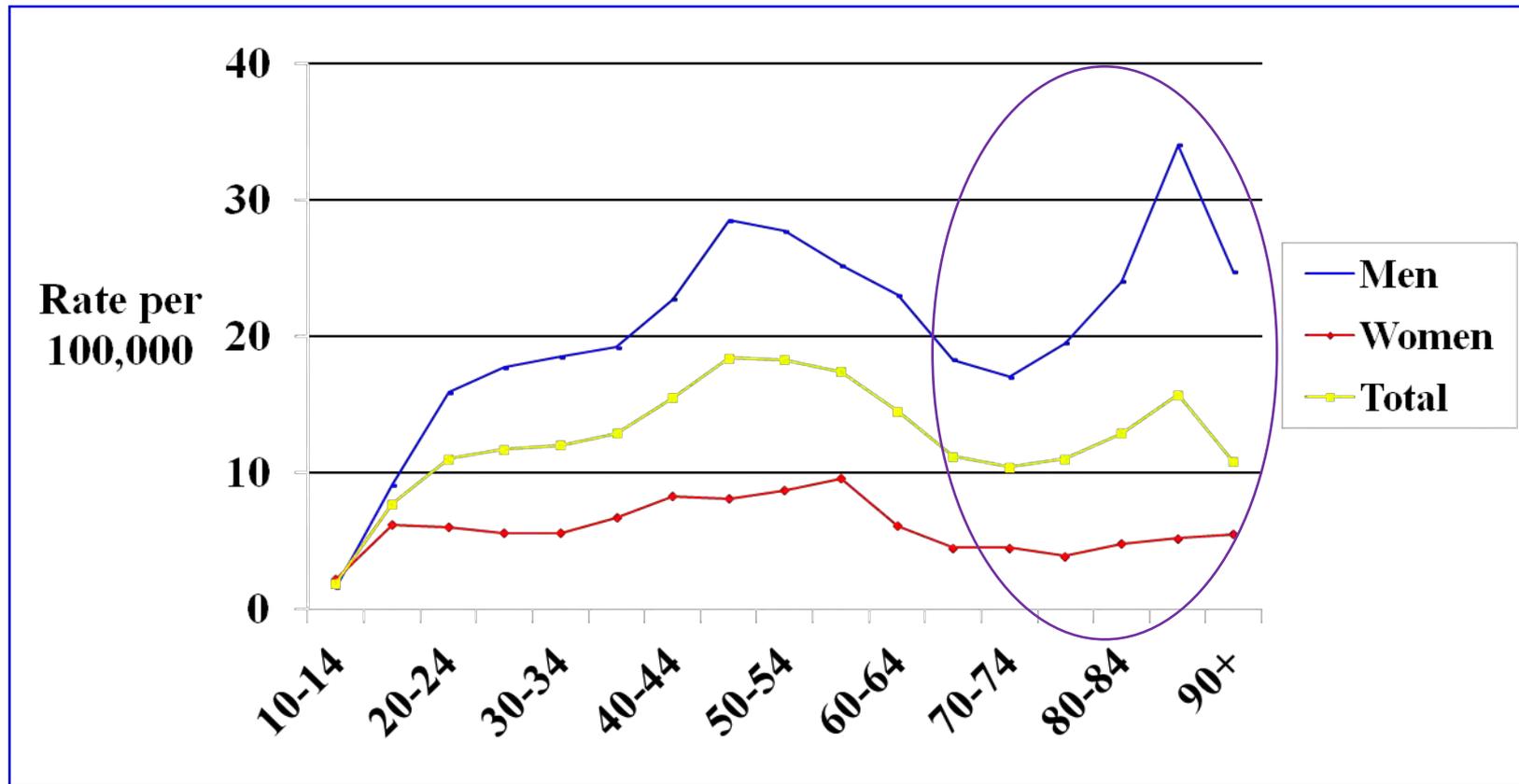
- The distribution of deaths by suicide in North America similarly demonstrates far higher suicide rates (and numbers of deaths by suicide) among men as compared with women
- This discrepancy generally increases over the life course, with the greatest discrepancy among older adults
- There has been recent increased interest in North America in focusing on suicide in the military and among middle-aged men

U.S. Suicide Rates by Age and Sex, 2014



Source: WISQARS

Canadian Suicide Rates by Age and Sex, 2013



Epidemiology of Suicide in Canada

- Statistics Canada reports that in 2013 there were 4,054 deaths due to suicide in Canada
- This includes 3,041 men (75%) and 1,013 women (25%)
- Statistics Canada reports a National (all ages) suicide rate of 11.5/100,000 in 2013
- Suicide rates are often undependable and underestimate “true” suicide rates, especially if means are equivocal (e.g., medication overdose, Ohberg & Lönnqvist, 1998)

- In order to effectively prevent suicide, interventions need to focus on high-risk groups
- Males accounted for 75% of those who died by suicide in Canada in 2013.
- Men generally use more violent and lethal means for suicide than women do, including use of firearms.
- In 2013, of the 4,054 individuals who died by suicide in Canada, 544 (14%) used a firearm; 97% were male, and 26% over 65.

- Researchers have been focusing increasingly on the role of gender in promulgating suicide risk among men
- Whereas “sex” is typically considered a biological variable (and typically treated as a binary variable in research), “gender” is considered to be socially-constructed, reflecting an aspect of one’s identity, with social, cultural, psychological, and biological contributing factors (and treated as continuous, fluid, or as having multiple categories or characteristics)

- The “gender paradox” (e.g., Canetto, 1997) of suicide indicates that women engage in self-harm behaviour more frequently than men (at least twice as often), while men die by suicide more frequently than women (roughly 4 times as often)
- Potent risk factors for suicide include prior self-harm behaviour and depression...both of which are more common in women

- “She died for love and he for glory”-Canetto
- Suicide in women is often characterized as passive, dependent, and weak; suicide in men is characterized as active, noble, and heroic
- Culture (and era) likely mediate means and interpretation of suicidal behaviour and deaths
- The above scenario is most common in European-American cultures

- Canetto has noted that “self-harm” or “suicide attempts” may be perceived as feminine behaviour, whereas “suicide” is perceived as masculine
- Hence, men may fear that if they survive a suicide attempt, they will be seen as feminine (or weak)
- Added to that is the European-American concept of men as being autonomous, in control, and capable...including of “getting the job done”

- 20+ years ago, Canetto noted that suicide researchers either ignored the issue of gender and suicide, or, if they did comment on it, tended to disparage women's moral, intellectual, or personality characteristics, rather than recognizing their lower rates of suicide as examples of strength and sources of resiliency in the face of adversity
- These days, men are being treated in a similar fashion in the literature, with masculinity (or masculine traits) disparaged as suicidogenic

- Healthcare service utilization is part of the problem
- Men are stereotypically less likely to seek healthcare and may be especially reluctant to seek out mental healthcare services, given concerns regarding perceptions of being seen as weak, ignorance of mental health services, work/career-related concerns, and the belief that they can handle it themselves

Utilization of Mental Healthcare Services

- Crabb & Hunsley (2006) examined data from the Canadian Community Health Survey exploring patterns of mental health service utilization among middle-aged (45-64 years), younger old (65-74), and older-old (75+) adults with/without depression
- Women were more likely to consult M.H. providers across age and depression groups
- Those more likely to consult a professional for M.H. concerns were more likely to be female, not married, of higher education, and with a greater number of chronic medical conditions

- With changes in social and economic factors in recent decades, gender role norms and expectancies have been shifting
- Many men are struggling to find their place in a society in which “traditional” masculine values no longer dominate (if they ever did), and trying to figure out who they are, who they should be, and how to fit in
- Concerns have been raised regarding the plight of young and middle-aged men

- Men are increasingly less likely to be attending post-secondary education (even in what had once been considered “male-dominated” fields of study), ultimately leading to lower SES and more precarious employment
- Fields with a high proportion of male workers (e.g., construction and manufacturing) were especially hard-hit by the “economic downturn” of 2008, leading to high rates of job loss and unemployment among men
- Some have linked this to recent high rates of suicide in middle-aged men



Preventing Suicide among Men in the Middle Years:

Recommendations for Suicide Prevention Programs



SPRC | Suicide Prevention Resource Center



- The SPRC report notes:

“although men in the middle years...35-64 years of age-represent 19 percent of the population of the United States, they account for 40 percent of the suicides in this country.”

- It also notes that the relative size of this demographic is growing steadily, necessitating focus on the issue of suicide prevention in MiMY.

- It cites, as key contributors “cultural expectations about masculine identity and behavior” including beliefs regarding men:
 - Being independent and competent
 - Concealing emotions
 - Being the family “breadwinner”

- It is recognized that there is no one “masculinity” but perhaps “masculinities”-or, better yet, traits and characteristics that have historically been ascribed to a certain concept of masculinity
- Perhaps the earliest attempt to assess masculinity (at least in Psychology) was via the Masculinity/Femininity scale on the MMPI; the purpose of this scale was largely to identify homosexuality, then considered a mental disorder

- Traditional or so-called “hegemonic” masculinity is currently being treated as the culprit responsible for high suicide rates in men
- Features of hegemonic masculinity include:
 - Competitiveness
 - Self-reliance
 - Stoicism
- It is described as patriarchal and involves the intent to subordinate women and other men

- David & Brannon (1976) identified four norms of traditional masculinity:
 1. “No sissy stuff”-i.e., avoid feminine traits
 2. “The big wheel”-i.e., success and achievement
 3. “The sturdy one”-i.e., never show weakness
 4. “Give ‘em hell”-i.e., promoting of adventure, and not shying away from violence

- Levant's Male Role Norms Inventory (MRNI) assesses 7 “theoretically-derived norms of traditional masculine ideology” including:
 - Avoidance of femininity
 - Fear and hatred of homosexuals
 - Self-reliance
 - Aggression
 - Achievement/Status
 - Non relational attitudes toward sex
 - Restrictive emotionality
- It also includes a non-traditional attitudes subscale

- Levant & Richmond (2007) summarized 25 years' worth of research with the MRNI, noting associations between traditional masculinity and:
 - Less relationship satisfaction
 - Less emotional openness
 - Beliefs regarding men's parenting roles
 - Lack of empathy regarding racism and sexual harassment
 - Sexual aggression
 - Alexithymia
 - Poor help-seeking

- Consider the title of a 2012 BMJ piece reporting on a recent report by the Samaritans on suicide: “Pressure to keep up macho image may be behind rise in suicides among men”
- The article actually highlights issues of relationship dissolution, loneliness, alcohol use, and emotional illiteracy as factors in suicide in middle-aged men
- I’m not so sure these reflect “machismo”

- Scourfield & Evans (2015) identified features of traditional masculinity that may account for men's elevated risk for suicide following relationship dissolution, including their perception that the breakup was an individual failure that negatively impacts their sense of honour, further linking it with their greater inflexibility, increasing loneliness and lack of supportive social relationships, and the likelihood of greater financial impact and loss of custody of their children

- Möller-Leimkühler (2003), in her analysis of the gender gap in suicide, commented on the negative role of individualism in conferring vulnerability for suicide in men, noting:

“reduced life chances, especially loss of work and long-term unemployment (which is still more substantial for male than for female identity), are rather attributed to personal failure than perceived as a societal problem, resulting in identity problems, loss of control, helplessness, and depression.”

- She goes on to say:

“Males respond to this with maladaptive coping strategies, triggered by norms of traditional masculinity or confusion resulting from gender-role conflict: emotional inexpressiveness, lack of help-seeking, aggressiveness, risk-taking behaviour, violence, alcohol and drug abuse and suicide.”

- Overall, this is not sounding good for men...
- ...but is that all there is to say on the issue?

- I find it hard to believe that certain characteristics that have been considered “masculine” in some contexts have no positive, noble, or even adaptive features
- What about: duty, responsibility, fidelity, steadfastness, serious-mindedness, work ethic, achievement-orientation, altruism, idealism, adventuresomeness, humour, and yes even caring for others and wanted to look out (or protect) the weaker or less fortunate?

- Månsdottor and colleagues (2009) investigated mortality data for 49,321 Swedish men who had been tested for compulsory military training in 1969
- They found that higher levels of traditional masculinity (rated by psychologists on a 1-5 scale) were associated with significantly LOWER risk for all-cause mortality and death by suicide, even controlling for childhood SES, smoking, alcohol intake, blood pressure, mental disorder, and police involvement
- So, there's hope for us yet...in 1969 Sweden

- Ultimately, more theory and research are needed, seeking to better understand treatment-seeking, healthcare beliefs, and the impact of these and other factors on the high prevalence of suicide among men, and to better understand potential sex and gender differences
- We need to do a better job of developing “gendered” approaches to suicide risk detection and intervention
- With that in mind, we now turn to our next two presentations



Man's Search for Meaning in the Transition to Retirement

Dr. Marnin J. Heisel, Ph.D., C.Psych.
and the Meaning-Centered Men's Group Project Team

Presented at the 18th Canadian Collaborative Mental
Health Care Conference (2017),
Ottawa, Ontario
June 3, 2017

Co-Investigators

- Sharon L. Moore, RN, Ph.D., C.Psych.
- Gordon L. Flett, Ph.D.
- Paul S. Links, M.D., FRCP(C)
- Ross M.G. Norman, Ph.D., C.Psych.
- Sisira Sarma, Ph.D.
- Rahel Eynan, Ph.D.
- Norm O'Rourke, Ph.D., R.Psych.

Collaborators:

- Kim Wilson, M.S.W., Ph.D.
- Paul Fairlie, Ph.D.

Community Partners:

- Third Age Outreach-St. Joseph's Health Care, London
 - Beverly Farrell, R/TRO
- Kiwanis Seniors and Community Centre City of London
- Canadian Coalition for Seniors' Mental Health
- Centre for Suicide Prevention (Calgary, Alberta)
 - Mara Grunau, M.A.

Acknowledgements: Funding Support

Project support for this study was generously provided by Movember Canada

Acknowledgements: Assistants & Trainees

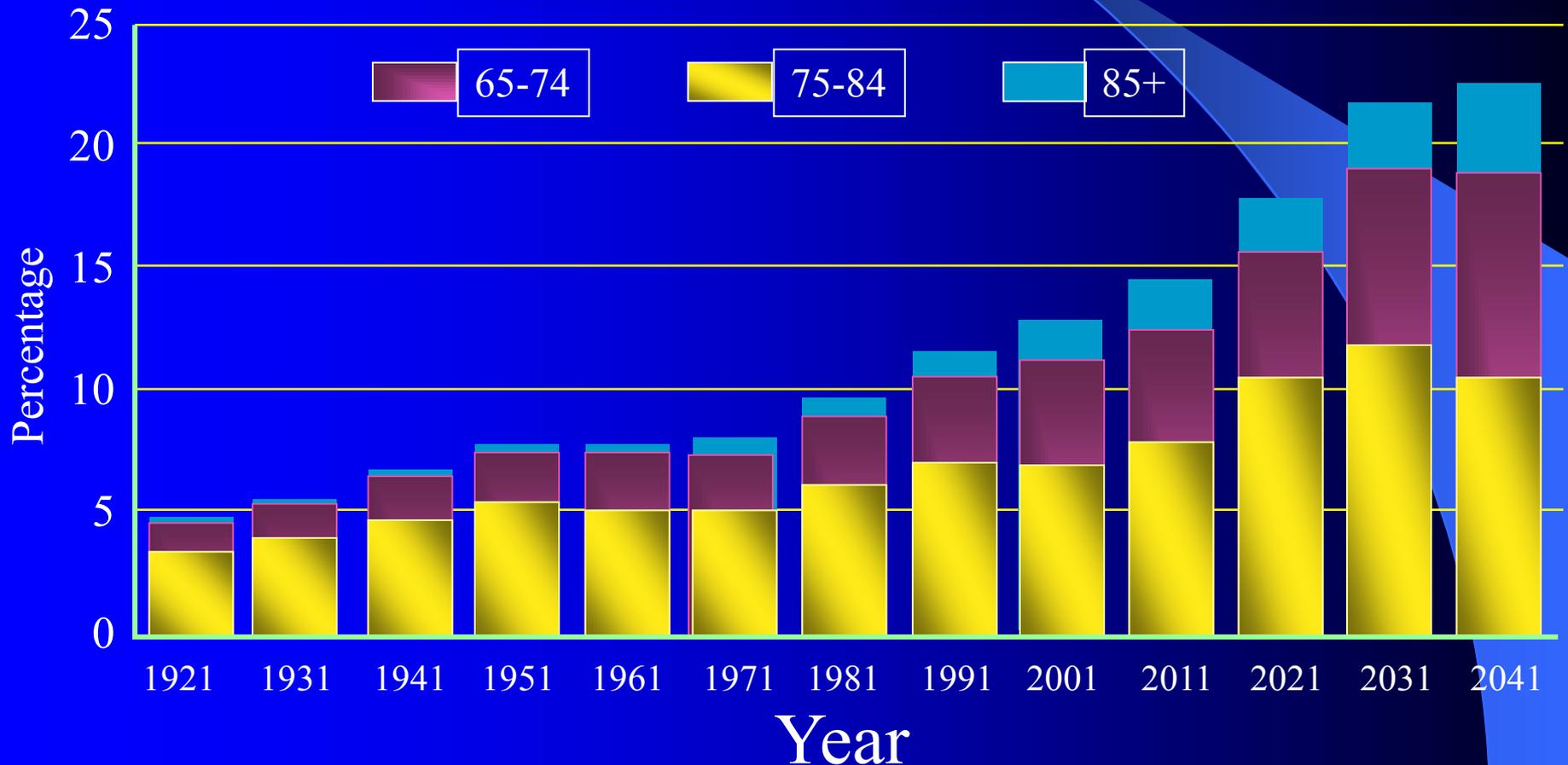
- Gina Bhullar
- Lindsay Cecile
- Greg Grogan
- Orsolya Gyorgy
- Dr. Theoren Judson
- Chloe Lau
- Dorian Murariu
- Sarah O'Flanagan
- Ben Peckham
- Paula Rayo
- Sophie Rosen
- Kristen Sanders
- Dr. Alina Sotskova
- Scott Squires
- Belal Zia

The Aging Population

- The older adult population is growing in North America and much of Europe (WHO, 2001) and could exceed 70 million North Americans by 2030 (U.S. National Institute on Aging).
- The Canadian older adult (65+) population numbered 5 million people in 2011 and is expected to reach 20-25% of the population by 2030 (Statistics Canada).

Older Adults (by age sub-groups) as % of the Total Population

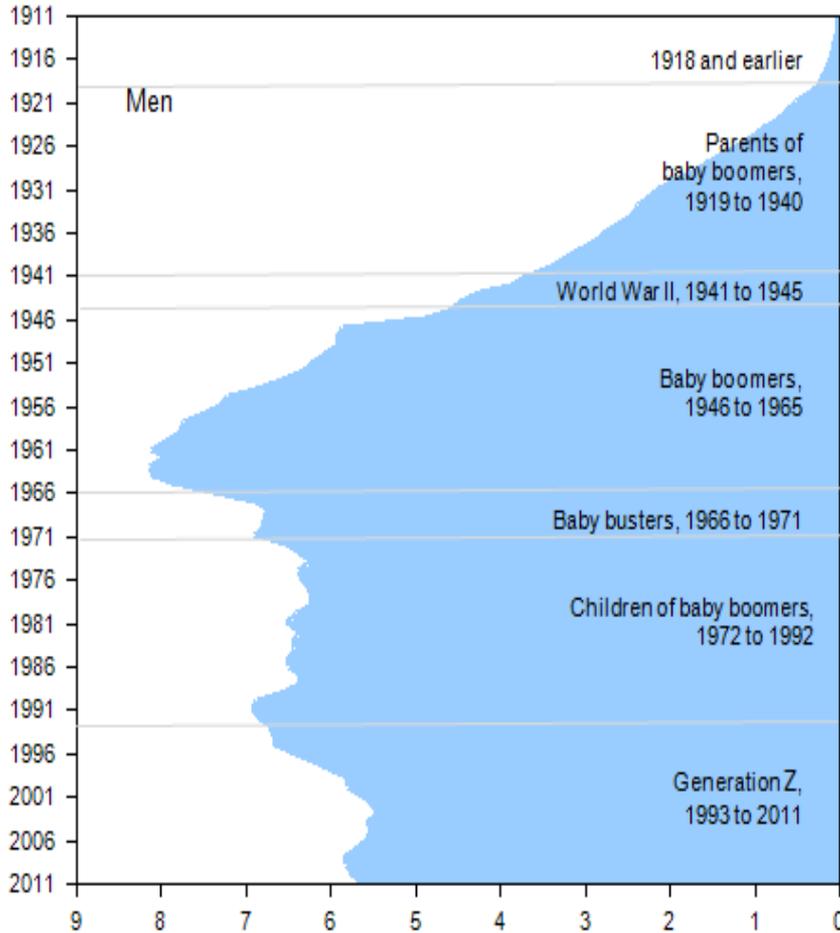
Canada, 1921-2041



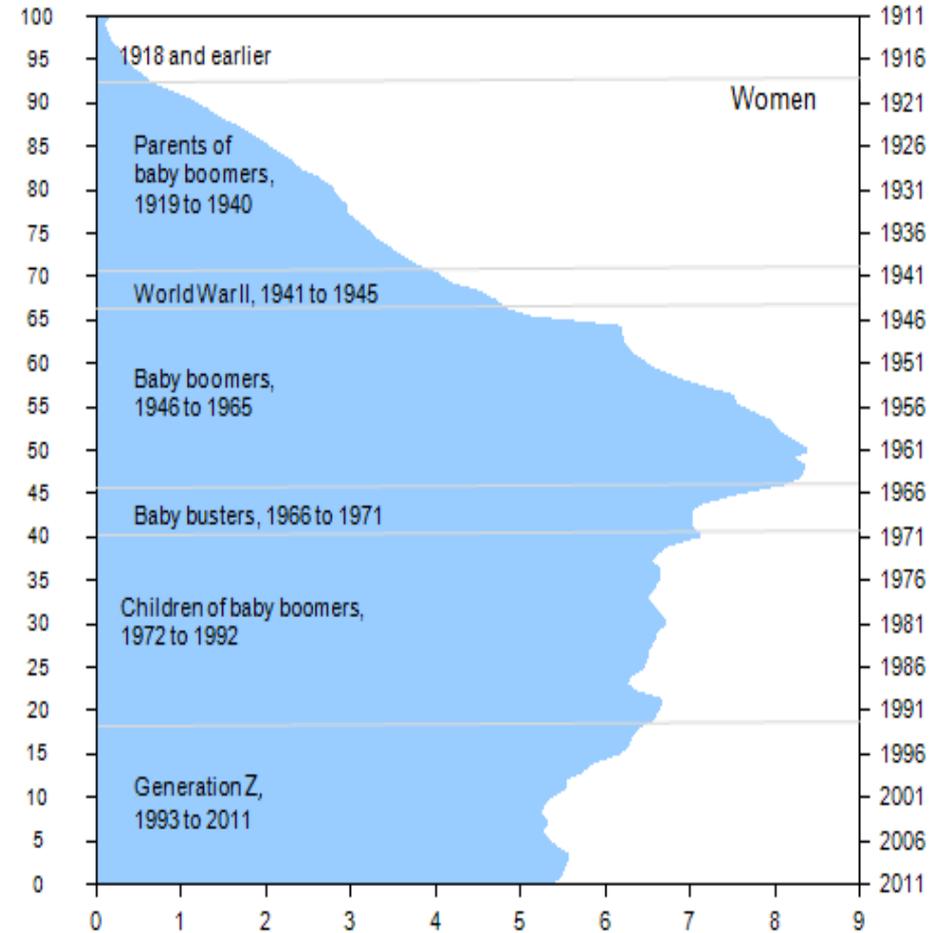
Source: The Canadian Coalition for Seniors' Mental Health

- The baby-boomers (DOB: 1946-1964) comprise our largest birth cohort; they began reaching their “senior” years in 2011.
- Shifting population demographics necessitate an increased focus on promoting health and psychological resiliency.

year of birth



age



per 1,000

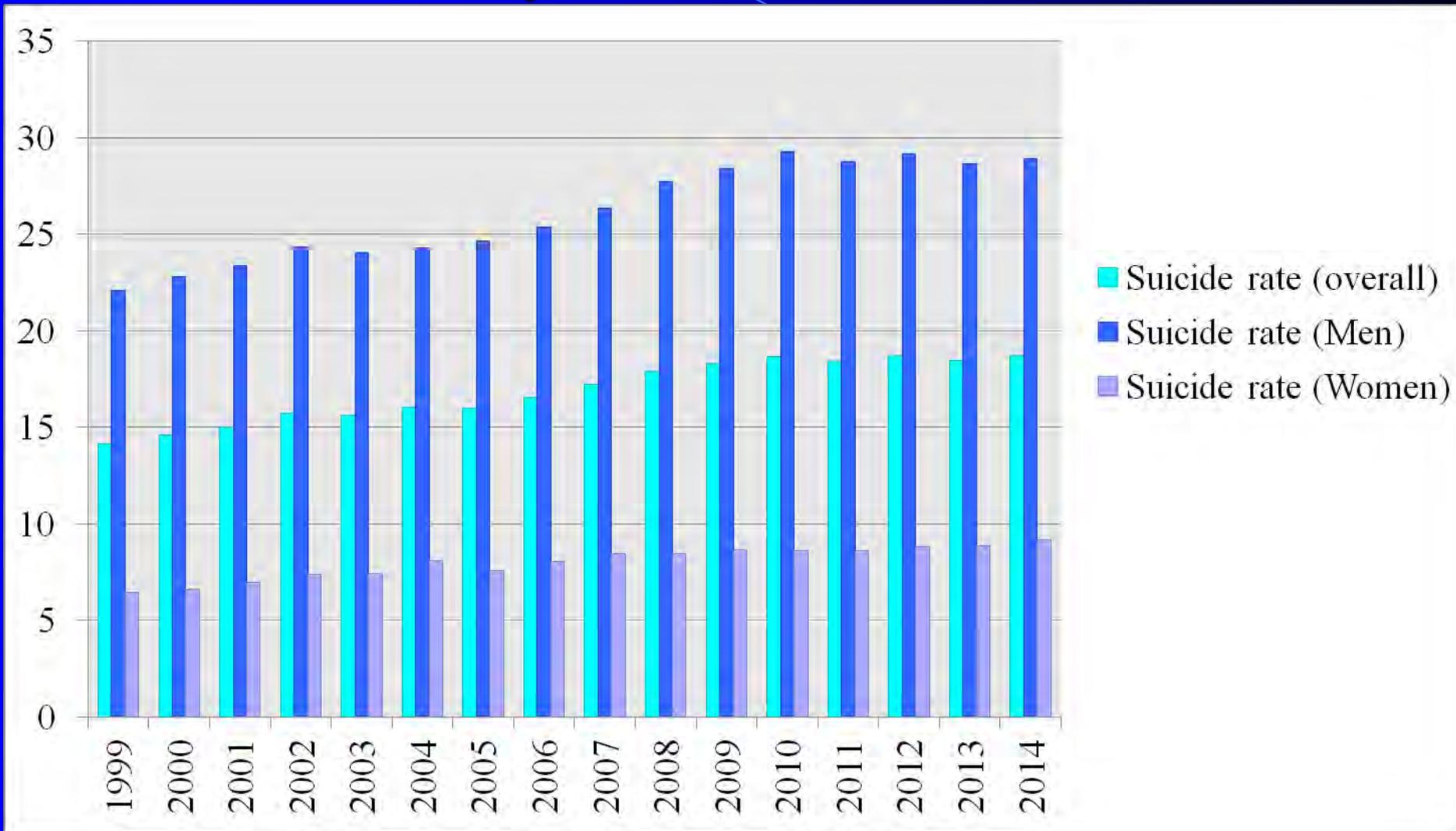
Source: Statistics Canada

“Portrait of Generations, Using the Age Pyramid, Canada, 2011”

Older Adult Suicide Prevention

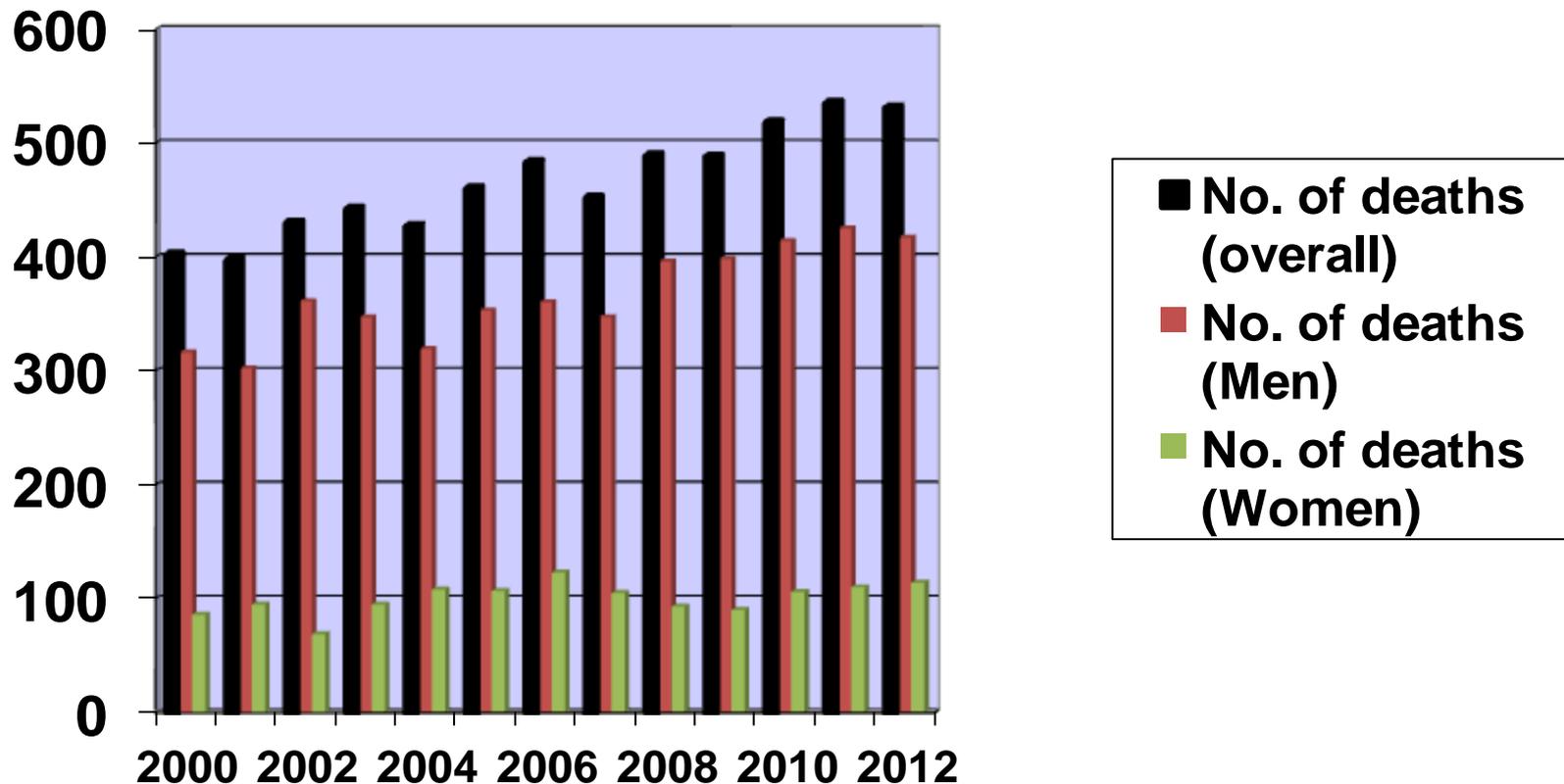
- Although many (if not most) older adults reach their senior years in reasonably good health, some struggle with transitions associated with aging and related psychopathology.
- 16,000+ North Americans over 55 die by suicide annually; this # is rising (CDC, StatsCan).
- “Baby boomers” have high rates of suicide
- This is especially true for men, who employ highly violent means of self-harm.

Suicide Rates by Sex among U.S. Baby-Boomers, 1999-2014



Source: WISQARS, U.S. CDC

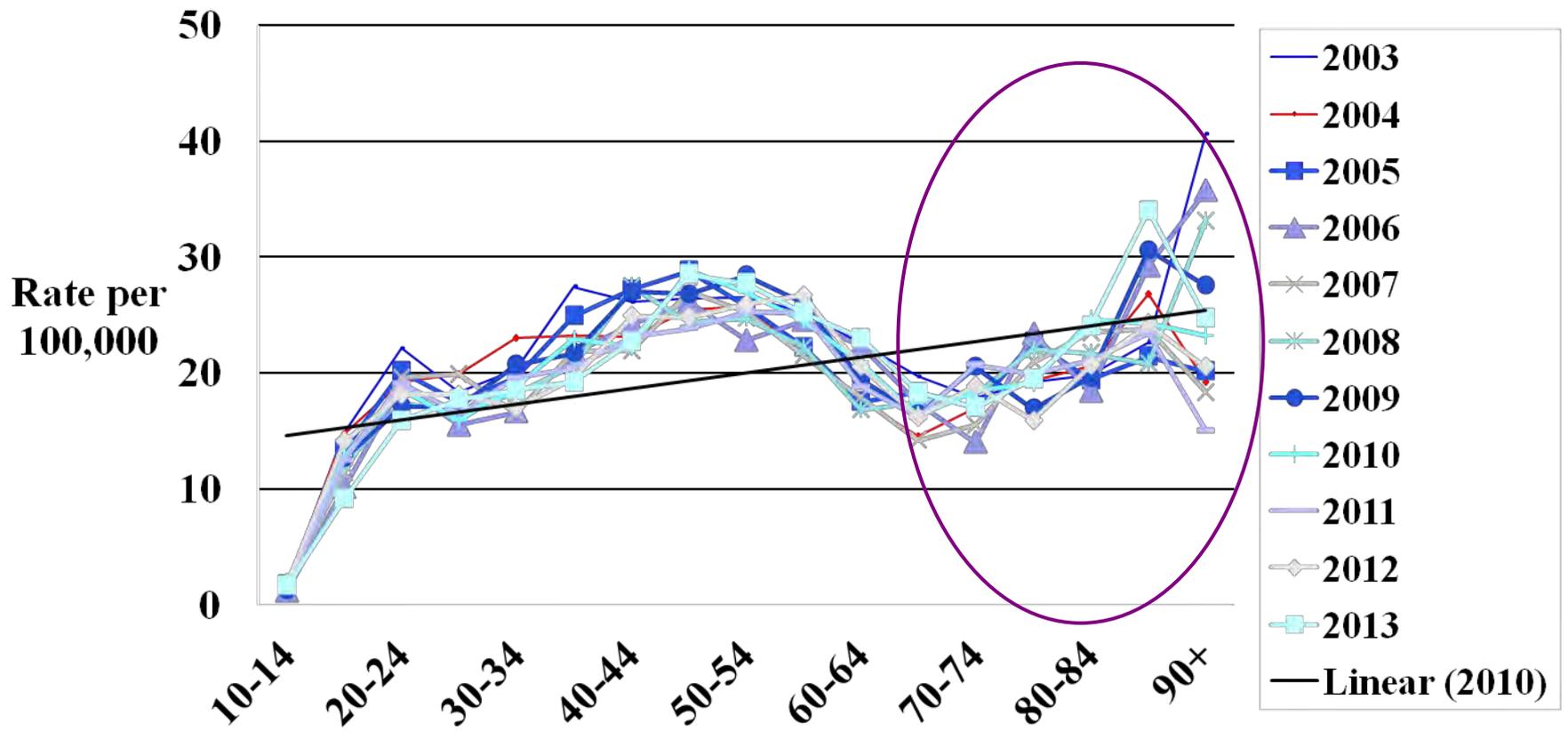
Raw Number of Deaths by Suicide by Sex among Older Adults in Canada, 2000-2012



Source: Statistics Canada, CANSIM

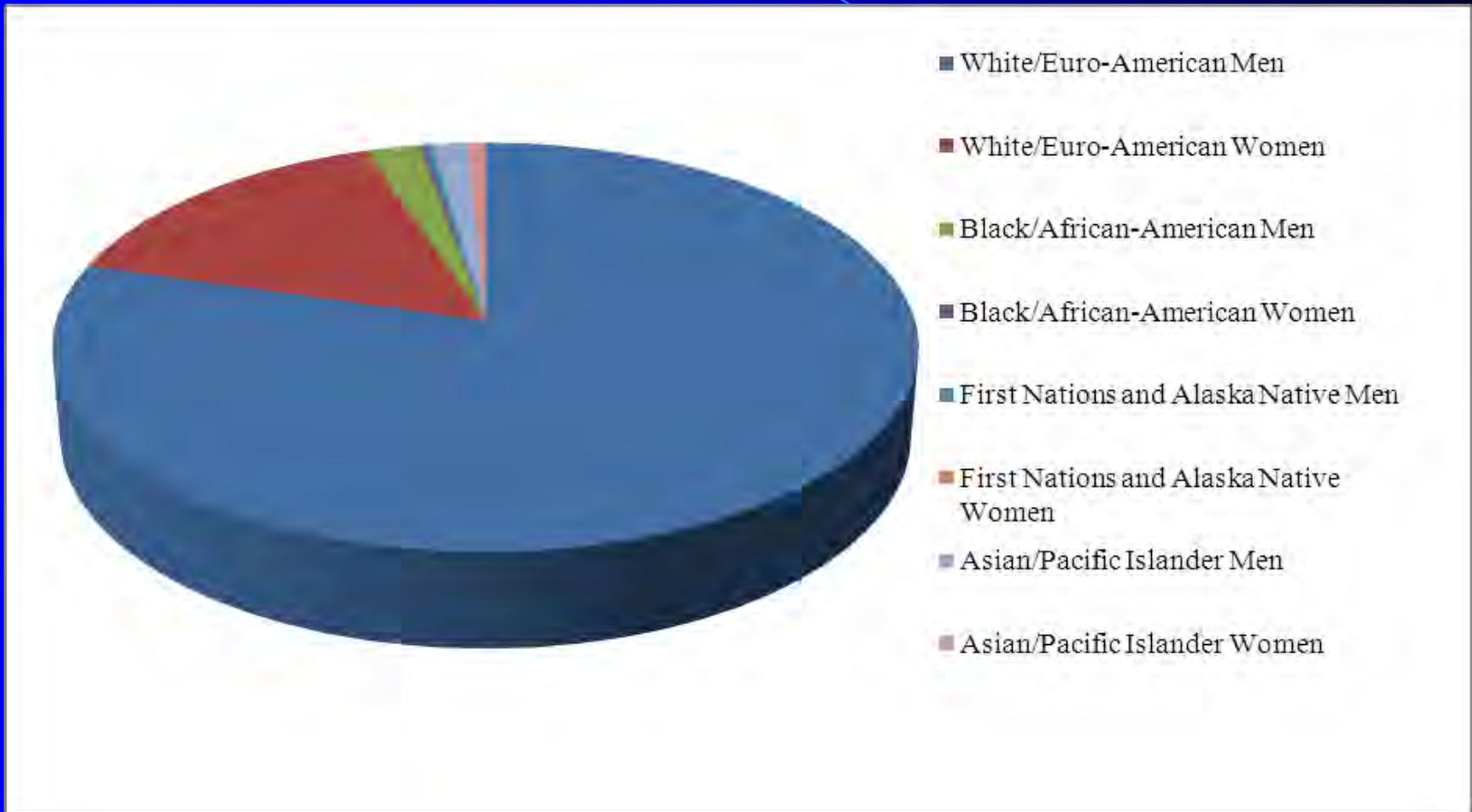
Canadian Suicide Rates for Men, by Year, 2003-2013

Chart Title



Source: Statistics Canada

2012 Distribution of Deaths by Suicide for Men and Women 65 Years and Older in the U.S.



Heisel & Duberstein, 2016

Clinical Implications/Opportunities

- Innovative models of outreach and health service delivery and training are needed, e.g.:
 - Access to psychological services for older adults
 - Collaborative/shared care approaches
 - Use of social service providers and peer supports
 - Use of telehealth and other technology
 - Improving educational training & implementation of evidence-supported practices in frontline care
 - Community outreach, support, and integration

- Community efforts that have shown promise in reducing suicide risk among older adults (e.g., DeLeo et al., 2002; Oyama et al., 2005) primarily benefit women, and not men.
- Interventions are needed that are tailored to at-risk demographics, such as older men.
- And yet men are less likely than women to access healthcare and mental health services, and have higher risk of suicide, which increases in the years following retirement.

- Many men enjoy healthy and satisfying post-employment years (Pinquart & Schindler, 2007; Quaade et al., 2002; Westerlund et al., 2009).
- However, retirement can unearth or exacerbate health & mental health problems (Butterworth et al., 2006; Gill et al., 2006; Karpansalo et al., 2005).
- Empirical findings indicate risk for post-retirement morbidity and mortality, including by suicide (Bamia, Trichopoulou, & Trichopoulos, 2008; Brockman, Müller, & Helmert, 2009; Qin, Agerbo, & Mortensen, 2003; Schneider et al., 2011).

- Focused interventions are needed that target middle-aged and older men potentially at-risk for suicide.
- There is a need to enhance men's capacities to cope with loss, adapt to changing life circumstances, seek and accept help, and nurture supportive and **meaningful interpersonal relationships**
- “Upstream” or preventive interventions are warranted that aim to enhance psychological resiliency, rather than merely respond after risk is manifest (CCSMH, 2006).

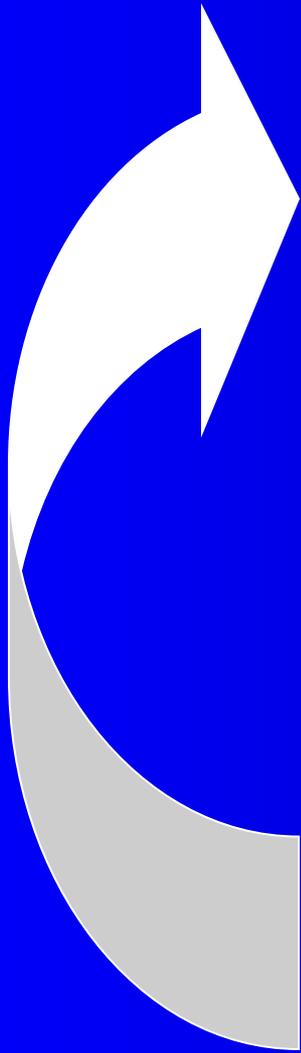
Prevention



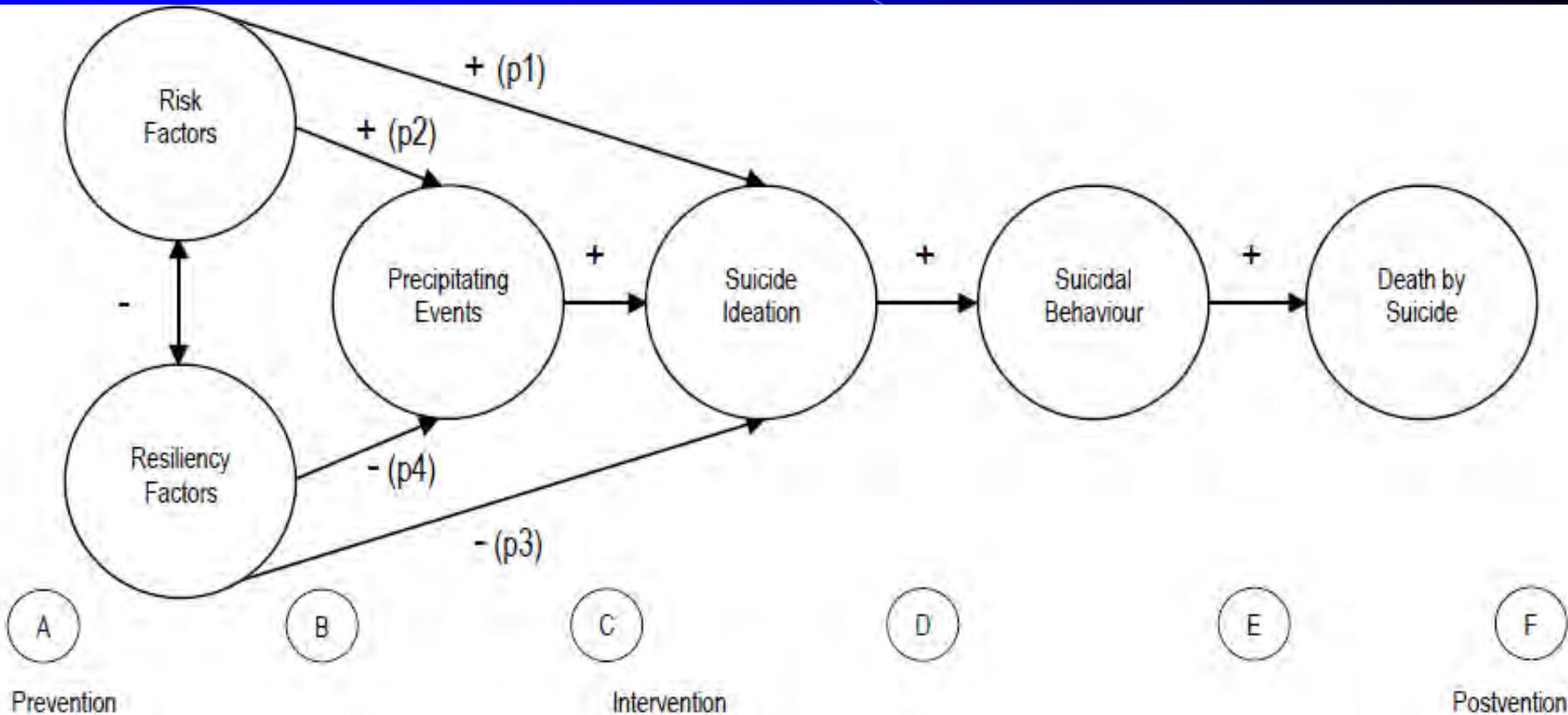
Intervention



Postvention



Our Theoretical Framework (e.g., Heisel & Flett, 2014)



- Socio-cultural factors contribute to suicide risk; approaches to mental health promotion and suicide prevention should thus be age-appropriate and honouring of clients' key values and concerns.
- Theory, research, and clinical experience suggest that individuals reporting more **Meaning in Life (MIL)** experience greater psychological well-being and are potentially protected against the advent of psychopathology and suicide risk.

- The Viennese psychiatrist, Viktor Emil Frankl (1905-1997), developed Logotherapy (literally “therapy through meaning”), as a meaning-centered theory and system of existential psychotherapy focusing on enhancing Meaning in Life (MIL).
- His work “Man’s Search for Meaning” describes his survival of Auschwitz, and the role played by meaning recognition in enhancing his own survival (and that of others), and in deterring suicidality.

Meaning in Life

“He who has a WHY to live for can bear with almost any HOW.”

Nietzsche quotation in Frankl's Man's Search for Meaning.

Meaning

- Not “semantics”
- Existential meaning (“what is meant”)
- A profound sense of coherence, purpose, or significance, unique to the individual
- Has inherent worth and value
- It has transcendence and intentionality

- Frankl indicated that we tend to find MIL in:
 - What we contribute to the world
(Creative MIL)
 - What we receive from the world
(Experiential MIL)
 - Our attitudes toward triumphs & challenges
(Attitudinal MIL)
 - Spirituality, transcendence, purpose, or connection to something beyond ourselves
(Ultimate MIL)

Parallel System of Meaning

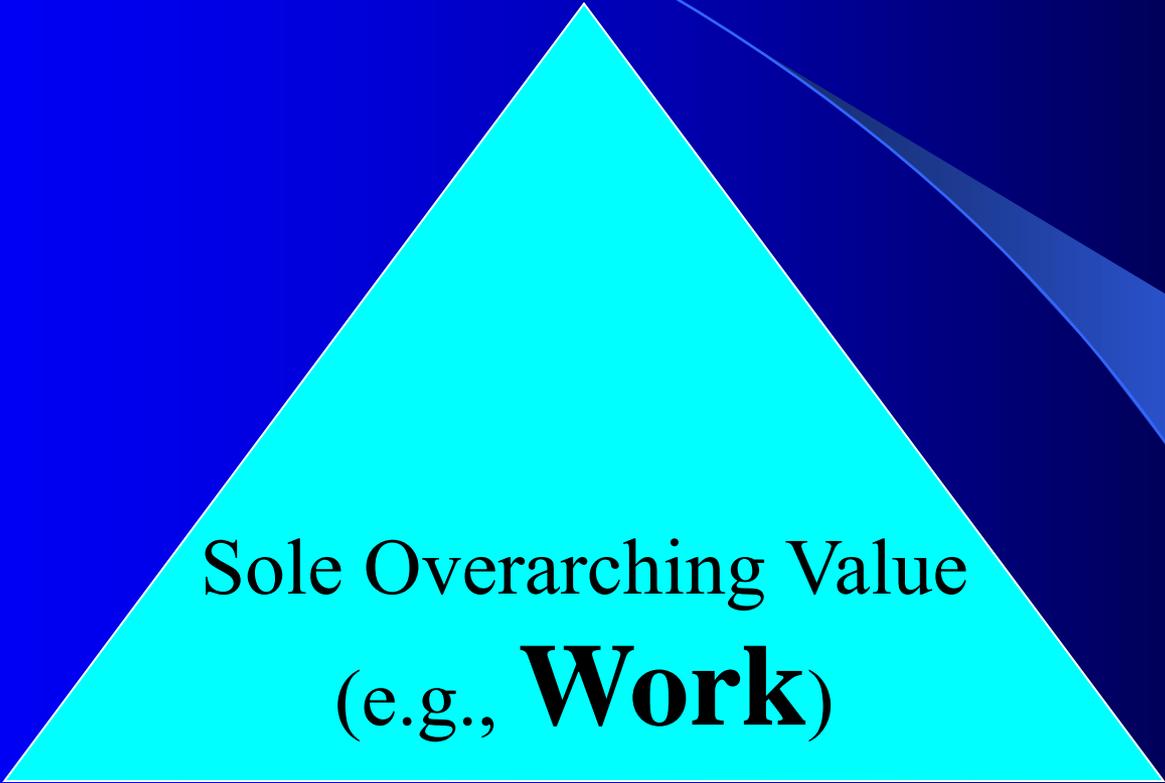
Family

Friends

Work

Hobbies

Pyramidal System of Meaning



Sole Overarching Value
(e.g., **Work**)

Research Findings

The background is a solid blue color. A thin, light blue curved line starts from the top left and arcs across the top of the page. A larger, darker blue wedge-shaped graphic is positioned on the right side, pointing towards the center of the page.

Meaning is Associated with Well-Being in Later Life

- Adjustment & **longevity** (O'Connor & Valerand, 1988)
- Changes in physical health (Heidrich, 1998)
- Autonomy, personal worth (Saul, 1993)
- Alzheimer caregivers (Farran et al., 1991)
- Seniors w/ dementia (Farran, 1997)
- Creativity (Hickson & Housley, 1997)
- Depression/optimism (Reker, 1997)
- Illness appraisal (Nesbitt & Heidrich, 2000)
- Successful aging (Wong, 1989)
- Depression (Prager et al., 1997)
- “grandparenting” program (Carney et al., 1987)
- **Suicide ideation** (Heisel & Flett, 2007, 2014)

- We have found MIL to be associated negatively with late-life depression, hopelessness, and suicide ideation, and positively with life satisfaction, psychological well-being, and Reasons for Living (Heisel & Flett, 2007, 2014; Heisel, Neufeld, & Flett, 2016)
- MIL was significantly negatively associated with the onset of suicide ideation over a 1-2 year period of time, controlling for demographics, daily hassles, and depressive symptoms (Heisel & Flett, 2016)
- MIL appears to be most protective against thoughts of suicide at higher levels of depressive symptom severity (Heisel & Flett, 2014)

- A growing body of research evidence supports meaning-centered interventions.
- Breitbart and colleagues (2015) found that terminally ill older participants in a meaning-centered psychotherapy group, based on Frankl's tenets, experienced a reduced desire to hasten death.
- These investigators are now testing individual and group-based meaning-centered psychotherapy with individuals with advanced-stage cancer.

Interpersonal Psychotherapy Study Findings (Heisel et al., 2015)

TABLE 2. Paired-Sample Statistics on Primary and Secondary Clinical Outcomes (N = 17)

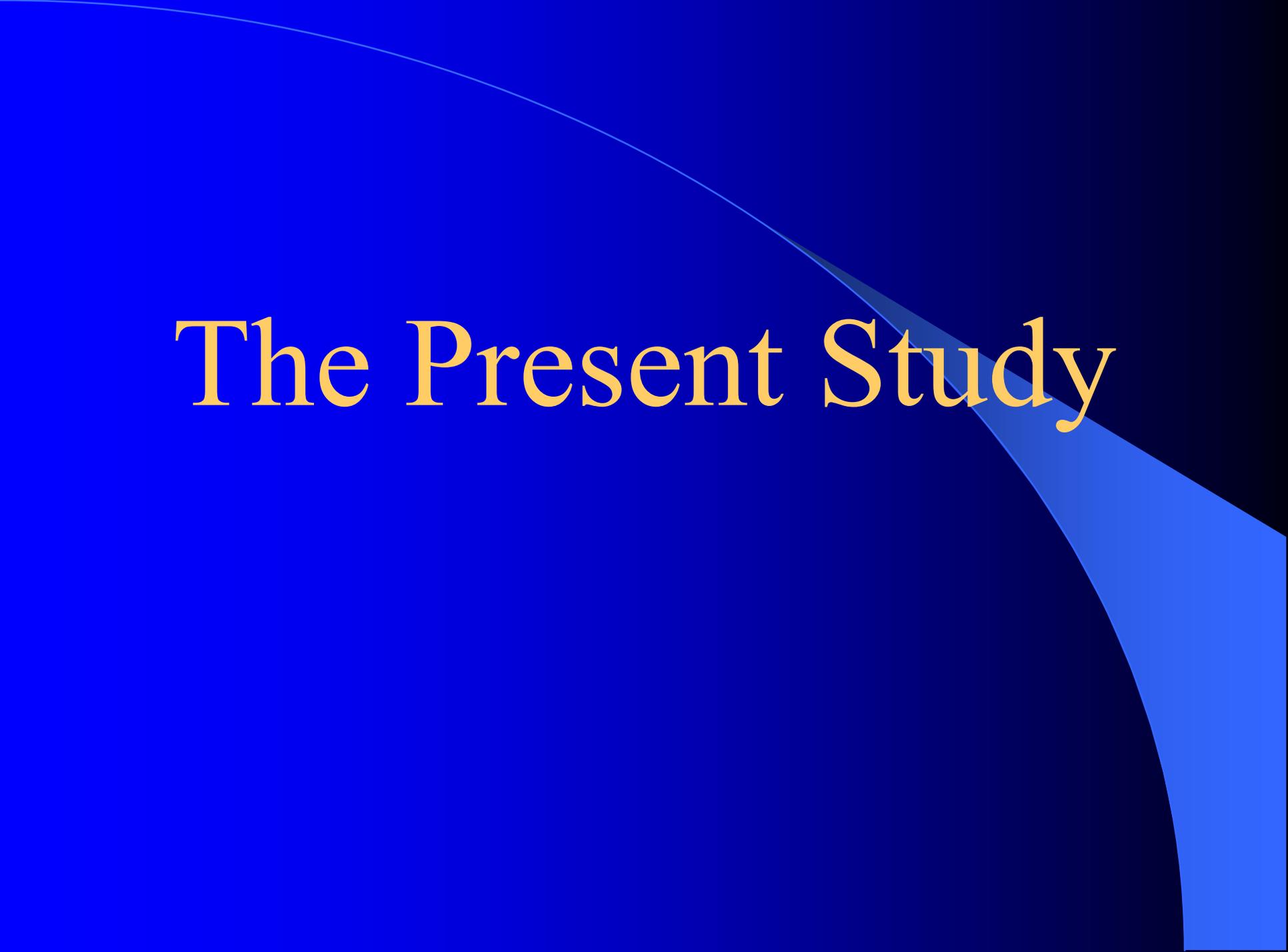
Severity of Suicide Ideation										
Variable	Pre-Treatment		Post-Treatment		Δ	SE	95% CI	t ^a	p	g
	M	SD	M	SD						
GSIS-Total	83.2	22.2	71.9	22.0	11.2	3.2	4.4–18.1	3.49	0.003	0.50
GSIS-SI	25.1	7.0	22.2	7.8	2.9	1.3	0.1–5.7	2.20	0.043	0.38
GSIS-DI	14.2	5.9	12.0	4.7	2.2	1.0	0.1–4.4	2.24	0.040	0.40
GSIS-LOSS	21.2	4.9	18.0	6.0	3.2	1.0	1.2–5.3	3.37	0.004	0.57
GSIS-MIL	19.8	6.9	16.9	6.0	2.8	1.0	0.7–5.0	2.76	0.014	0.44

Depression Symptom Severity										
Variable	Pre-Treatment		Post-Treatment		Δ	SE	95% CI	t	p	g
	M	SD	M	SD						
Ham-D	23.8	9.2	15.2	9.7	8.6	2.2	3.9–13.3	3.84	0.001	0.89
CESD-R	23.6	13.7	14.1	14.5	9.6	2.5	4.3–14.8	3.88	0.001	0.66

Notes: |Δ|: absolute value of the mean change score; SE: standard error for the absolute mean change score; 95% CI: 95% confidence interval around the absolute mean change score; |t|: absolute value of the t-score; |g|: absolute value of Hedges' unbiased estimator of effect size; GSIS: Geriatric Suicide Ideation Scale; GSIS-TOT: GSIS Totals; GSIS-SI: GSIS Suicide Ideation subscale; GSIS-DI: GSIS Death Ideation subscale; GSIS-LOSS: GSIS Loss of Personal and Social Worth subscale; GSIS-MIL: GSIS Perceived Meaning in Life subscale; SSI-C: Scale for Suicide Ideation for the Current week; HAMD: Hamilton Rating Scale for Depression; CESD-R: Center for Epidemiologic Studies-Depression scale-Revised.

^adf = 16.

The Present Study



Study Aims

- Aim 1: To assess the tolerability and acceptability of meaning-centered groups for men facing retirement.
- Aim 2: To test the effectiveness of men's groups in enhancing MIL and well-being and reducing the severity of symptoms of depression, hopelessness, and suicide ideation.
- Aim 3: To evaluate the cost-effectiveness of our group intervention in community settings.
- Aim 4: To evaluate facilitator training and dissemination of our group beyond Ontario.

Study Phases (N=80-100)

1. We will initially deliver a course of our group focusing on finalizing our intervention (n=10-12)
2. We will next deliver our finalized group and assess pre-mid-post and 3- and 6-month follow-up assessments in uncontrolled analyses (n=10-12)
3. We will conduct a non-randomized trial of Meaning-Centered Men's Group vs. weekly current events discussion groups (n=40-48)
4. Dissemination/Training to colleagues in Calgary and ~~Vancouver~~ to each deliver 1 group (n=20-24)

Recruitment: *Revised* Eligibility Criteria

- Men over the age of ~~60~~ *55*
- Who speak and understand English
- Are cognitively-intact
- Do not have a current *untreated* mental disorder
- Do not have severe suicide ideation
- And who:
 - Retired within the past *five* years, or
 - Will retire in the coming *two* years, or
 - Are in the process of retiring, and
- Are *concerned about or* struggling to find Meaning in Life in the context of the transition to retirement

- Groups consist of 12-session courses of 90-minute once-weekly sessions
- They take place in a community centre, not in a hospital or clinic
- Participants include 10-12 men, transitioning to retirement, and 2 facilitators: a mental health professional and a community service worker (to enhance sustainability)
- We request on-going feedback from group members and are creating a (loosely-structured) MCMG manual

- Group meetings focus on discussions of:
 - Meaning in work and career
 - Meaning in productivity and societal contribution
 - Meaning in mentorship and volunteerism
 - Meaning in leisure and recreation
 - Meaning in relationships, love, and friendship
 - Attitudes towards life's challenges and transitions
 - Attitudes towards positive experiences
 - Meaning and generativity

Our Experience to Date

A decorative graphic consisting of a large, light blue arc that starts at the top left and curves towards the bottom right, set against a solid black background. The arc is thicker on the right side, creating a sense of depth and movement.

Recruitment

- We have posted/distributed flyers in/with:
 - Coffee shops, barber shops, and menswear shops
 - Bookstores and libraries
 - Banks, financial planners, accountants, and lawyers
 - Employers, unions, and work support programs
 - Grocery stores, pharmacies, and liquor stores
 - Faith communities/places of worship
 - Community centres and wellness fairs
 - Service clubs, lodges, and men's clubs
 - Golf, curling, and fitness clubs, and arenas
 - Bingo parlors
 - Theatres
 - Newsletters, list-serves, and e-mail blasts
 - Word of mouth (including to women!)

- We have attended:
 - recreation (REXPO) and employment fairs
 - a lifelong learning group's (SLR) open houses
 - CARP meetings
 - men's lunch and learning groups
 - a custom car show
- We have presented to local financial planners
- We have sent out study information via an elder care informational list-serve
- We have contacted medical walk-in clinics and other providers
- We hosted a community retirement fair for men

Men's Retirement & Leisure Fair

a Movember kickoff event

speakers ♦ exhibitors ♦ workshops

Keynote Speaker:

Steve Ludzik

Former NHL player/coach & writer

Prizes ♦ Coffee ♦ Snacks



Nov 1, 11am-4pm
Covent Garden Market
Upper Mezzanine
www.MensFair2015.com

free

all are welcome



Preliminary Results:
Groups 1 through 4

Current Status

- We anticipate starting our next controlled course of MCMG in June; we may offer a 3rd set of groups.
- We are now recruiting for our Calgary group.
- We are planning to offer a group in Toronto.

Future Plans

- We are planning to conduct a larger RCT of MCMG with longer-term follow-up and to investigate potential treatment moderators
- We will be piloting a course of MCMG adapted for Canadian veterans and are planning a larger controlled trial with veterans at the time of Military Civilian Transition.
- We are also looking into other adaptations for individuals struggling with life transitions (including partners of individuals with breast cancer, and/or men struggling in the workplace).
- We have had repeated requests to offer a group for women.

Summary

- Psychological intervention research with men in their middle years and beyond necessitates innovative approaches to participant recruitment.
- Initial findings are promising for MCMG.
- Tolerance and acceptability were evidenced by strong attendance and satisfaction with group.
- Participants in both groups enjoyed their group experience, and many have continued to meet.
- Participants experienced a significant reduction in suicide ideation and other mental health problems and a significant improvement in well-being.

- It is too early to say much about between-group differences; but MCMG had fewer drop-outs and participants seemed to engage in deeper emotional processing/cohesiveness
- A randomized controlled trial is ultimately needed, investigating tx outcomes and moderators.
- We have been repeatedly asked us to offer groups for women struggling to transition to retirement.
- We hope that MCMG may ultimately become part of work outplacement for individuals facing retirement and be routinely offered in community settings.

The background is a solid blue color. A thin, light blue curved line starts from the top left and arcs towards the right. On the right side, there is a large, light blue triangular shape that points towards the center, overlapping the curved line.

Thank You