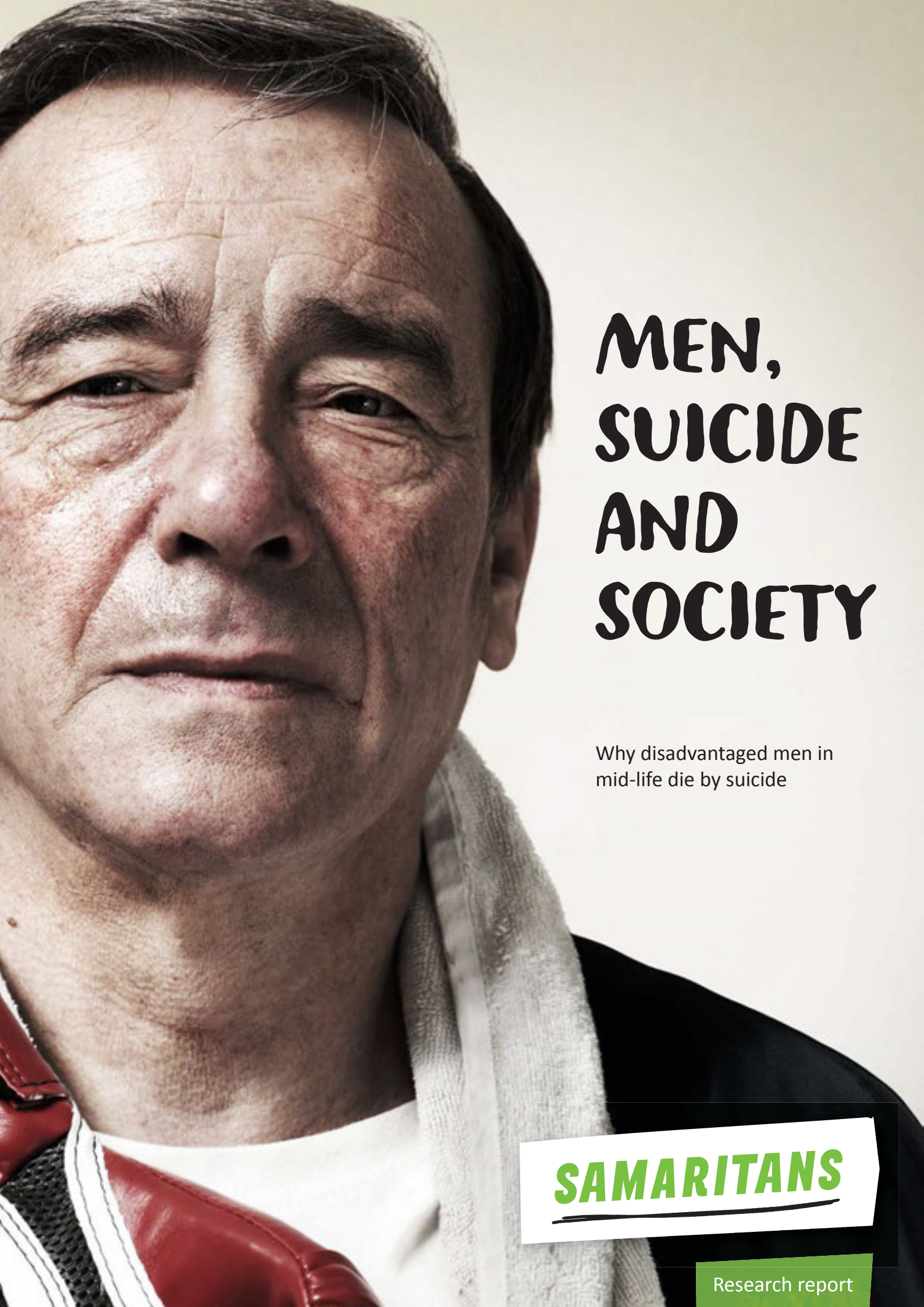

MEN, SUICIDE AND SOCIETY

Why disadvantaged men in mid-life die by suicide

SAMARITANS

Research report

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Foreword

Each and every suicide is a tragedy which has devastating effect on families, friends, colleagues and the wider community. For nearly 60 years, Samaritans has been leading the way to reduce suicide by making it possible for people to go on living. People contact us when they are struggling to cope and need someone to talk to. Our confidential helpline is open around the clock, every day of the year, providing a safe place for people to talk.

The gender disparity in death by suicide is often mentioned - men are three times more likely than women to die by suicide. Even more glaring is the socio-economic inequality in suicide risk - with those in the poorest socio-economic circumstances approximately ten times more at risk than those in the most affluent conditions. The high suicide rates in young men have always received considerable public attention, despite the fact that the rates in middle aged men have been at a comparable level over the past 40 years. More recently middle aged men have become the age group at highest risk, particularly those who are socio-economically disadvantaged.

This research has allowed us to really get behind the statistics and look into the real lives of these men to understand why. The vision of Samaritans is that fewer people die by suicide, and to make this vision a reality we need to understand what it is that brings so many middle aged men to the point of choosing to end their lives.

Samaritans works by listening. Our volunteers give up thousands of hours every year so that there is always a caring person who will listen. We are listening to this middle aged man. The research in this report will help us understand his reasons. It will help us provide him support, support that will help him to decide to go on living.

Stephen Hoddell

Stephen Hoddell
Chair of Samaritans

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Executive summary

This report seeks to explain why men of low socio-economic position in their mid-years are excessively vulnerable to death by suicide and provides recommendations to reduce these unnecessary deaths.

The report goes beyond the existing body of suicide research and the statistics, to try and understand life for this group of men, and *why* they may come to feel without purpose, meaning or value.

The key message from the report is that suicide needs to be addressed as a health and gender inequality – an avoidable difference in health and length of life that results from being poor and disadvantaged; and an issue that affects men more because of the way society expects them to behave. It is time to extend suicide prevention beyond its focus on individual mental health problems, to understand the social and cultural context which contributes to people feeling they wish to die.

Approach

Samaritans commissioned five leading social scientists to review evidence and theory in psychology, sociology, economics and gender studies. The report takes as given that mental health problems play a role in most suicides.

Psychological and personality factors

Some personality traits and 'mind-sets' contribute to the development of suicidal thoughts, including the belief that you must always meet the expectations of others; self-criticism; brooding; having no positive thoughts about the future and reduced social problem-solving ability. These traits can interact with factors such as deprivation, and triggering events such as relationship breakdown or job loss, to increase suicide risk.

Masculinities

Masculinity – the way men are brought up to behave and the roles, attributes and behaviours that society expects of them – contributes to suicide in men. Men compare themselves against a masculine 'gold standard' which prizes power, control and invincibility. When men believe they are not meeting this standard, they feel a sense of shame and defeat. Having a job and being able to provide for your family is central to 'being a man', particularly for working class men. Masculinity is associated with control, but when men are depressed or in crisis, they can feel out of control. This can propel some men towards suicidal behaviour as a way of regaining control. Men are more likely to use drugs or alcohol in response to distress.

Relationship breakdown

Relationship breakdown is more likely to lead men, rather than women, to suicide. Men rely more on their partners for emotional support and suffer this loss more acutely. Honour is also part of masculinity, and to be 'disrespected' in front of others by the actions of their partner (infidelity or abandonment) may lead to shame and/or impulsive reactions, perhaps to punish ex-partners. Men are more likely to be separated from their children and this plays a role in some men's suicides.

Emotional lives and social disconnectedness

The way men are taught, through childhood, to be 'manly' does not emphasise social and emotional skills. Men can experience a 'big build' of distress, which can culminate in crisis. Men in mid-life are dependent primarily on female partners for emotional support. Women help them to recognise their own distress, provide them with care and encourage them to seek help. Women maintain close same-sex relationships across their lives, but men's peer relationships drop away after the age of 30. Women are much more open to talking about emotions than men of all ages and social classes. Male friendships tend to be based on companionship through doing activities together. The 'healthy' ways men cope are using music or exercise to manage stress or worry, rather than 'talking'. Men are much less likely than women to have a positive view of counselling or therapy. However, both men and women make use of these services at times of crisis.

Men in their mid-years today

Mid-life has traditionally been viewed as the prime of life. However, there is evidence of mental ill-health and a dip in subjective wellbeing among people in their mid-years, compared to young and older people. Problems with relationships and employment during mid-life are experienced intensely, because by this life-stage, people have typically invested a great deal in work and relationships and the possibilities for making changes in these areas are limited.

Men currently in their mid-years are the 'buffer' generation – caught between the traditional silent, strong, austere masculinity of their fathers and the more progressive, open and individualistic generation of their sons. They do not know which of these ways of life and masculine cultures to follow. In addition, since the 1970s, several social changes have impacted on personal lives, including rising female employment, increased partnering and de-partnering and solo-living. As a result, men in mid-life are increasingly likely to be living on their own, with little or no experience of coping emotionally or seeking help on their own, and few supportive relationships to fall back on.

Socio-economic position

There are systematic socio-economic inequalities in suicide risk. Socio-economic position can be defined in many ways – by job, class, education, income, or housing. Whichever indicator is used, people in the lower positions are at higher risk of suicide. As you go down each rung of the social ladder, the risk of suicide increases, even after taking into account underlying mental health problems. There is debate over precisely how low social position increases suicide risk. Suggestions include having many more adverse experiences, powerlessness, stigma and disrespect, social exclusion, poor mental health and unhealthy lifestyles.

Unemployment in the UK is higher among men than women. This is related to the decline of predominantly male types of employment, such as manufacturing. Men have also been affected by the

general trend towards irregular work patterns, insecure or temporary work and self-employment, and the current recession.

Conclusions

Suicide is an individual act, the tragic culmination of mental health problems, feelings of defeat, entrapment, that one is worthless, unloved and does not matter. However, these feelings are produced within a specific social, economic and cultural context. This report shows that there have been a number of significant changes in society over the last 50 years – the shift from repressive pre-war to liberal post-war culture; changes to the roles of men and women and to the structures of families; economic restructuring and the decline of traditionally male industries. The impact of these processes has not been uniform across society; they pose challenges in particular to the group of men currently in mid-life, and these challenges are exacerbated when men occupy low socio-economic positions. The social context means this group of men is likely to experience multiple risk factors for suicide, interacting in devastating combination. They have seen their jobs, relationships and identity blown apart. There is a large gap between the reality of life for such men and the masculine ideal.

Recommendations

Samaritans calls on national government, statutory services (such as health, welfare, employment and social services), local authorities and the third sector to take action to reduce suicide in disadvantaged men in mid-life. Our recommendations are:

1. **Ensure that suicide prevention strategies include explicit aims to reduce socio-economic inequalities and gender inequalities in suicide.**
2. **Inform suicide prevention measures with an understanding of men's beliefs, concerns and contexts – in particular their views of what it is to 'be a man'.**
3. **Enable inter-agency working to address the multiple difficulties experienced by men in mid-life, through clear allocation of responsibility and accountability for suicide prevention at local level.**
4. **Support GPs to identify and respond to distress in men, recognising that GPs are the most likely formal source of help to be consulted by this age-group.**
5. **Provide therapies which address the specific psychological factors associated with suicide – particularly, for men, social and emotional skills, managing stress and the expectations of others.**
6. **Develop innovative approaches to working with men that build on the ways men do 'get through' in everyday life.**
7. **Join up alcohol and drugs strategies and services with suicide prevention, recognising the links between substance misuse, masculinity, deprivation and suicide.**
8. **Recognise the profound role of social disconnection in the suicide risk of men in mid-life, and support men to build social relationships.**
9. **Assist men excluded from the labour market to (re)enter employment.**

Introduction

This report seeks to explain why men of lower socio-economic position in their mid-years are excessively vulnerable to death by suicide. Drawing on theory and evidence from a range of disciplines, including sociology, psychology, economics and gender studies, it aims to inform policy and practice, with a view to reducing suicide in this group of men.

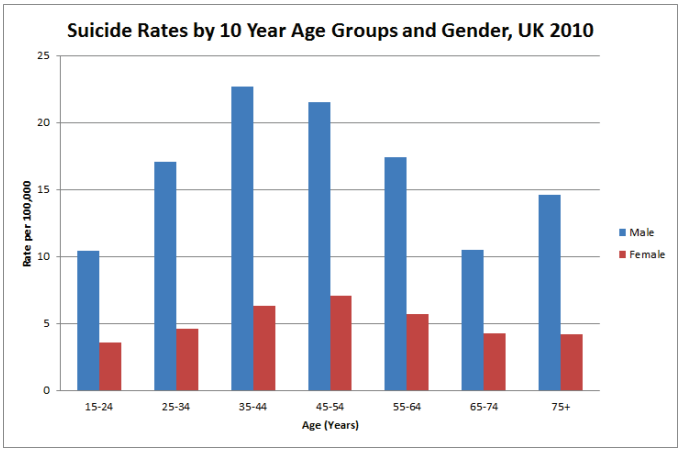
Why the focus on men of lower socio-economic position in mid-life

Men of lower socio-economic position in their mid-years are excessively vulnerable to death by suicide (compared to males in other age groups and compared to females of all ages) (Kreitman et al., 1991; General Register Office for Scotland, 2012; Department of Health, 2011; Tomlinson, 2012).

Death by suicide can be described as a problem of men. Suicide incidence is higher among men than women across the western world. In the UK, men are three times more likely than women to end their own lives. The male to female ratio for completed suicide has increased over time in the UK; rates of suicide among women have steadily decreased over the last 50 years, while suicide rates among men overall are at comparable levels to the 1960s.

Popular and scholarly attention has focused on the vulnerability of young men to suicide (Scourfield, 2005; Shiner et al., 2009; McDowell, 2000; Tomlinson, 2012). In the latter decades of the 20th century, suicide rates fell in older men (over 55), and rose in young men (under 35). While the suicide rate rose more dramatically for younger men and garnered more attention, over the years 1970 to 1991, the suicide rate for men in their mid-years (35–54) also rose – more gradually, from a higher base, but reaching the same levels as the rate for younger men – and then levelled off. Over the last decade, there has been evidence of a fall in suicide among young men, although the rate remains high in comparison with the general population. Thus over the last 40 years, the suicide rate in men in mid-life has been at a comparable level to that of younger men, and for most of the last 10 years the peak suicide rates have been in men in their mid-years (Department of Health, 2011; General Register Office for Scotland, 2012; Tomlinson, 2012). However, this group has had little attention in research, policy or public discourse.

Graph 1[1]



There is a gradient in suicide risk by occupational social class (and other markers of socio-economic position): those in the lowest socio-economic group and living in the most deprived areas are 10 times more at risk of suicide than those in the most affluent group living in the most affluent areas (Platt, 2011). Kreitman et al. (1991) looked at suicide risk in different age, gender and social class combinations and found the highest risk in males in the lowest social class in their mid-years.

The individual risk factors for suicide are well-established in the quantitative literature – low socio-economic position, relationship breakdown, isolation, gender, mental health problems. What this report seeks to provide is insight into the

interaction between these factors, and why and how they matter to men in men in mid-life in this historical period.

Why Samaritans produced this report

Samaritans' vision is that fewer people die by suicide. We provide around-the-clock helpline services; deliver projects to reach vulnerable people and reduce suicide in schools, prisons, health services, communities, etc; and influence public policy and other service providers.

In 2010, Samaritans and Network Rail embarked on a five-year partnership to reduce the number of suicides on the railways. This includes communications campaigns to increase awareness of Samaritans services, targeted at high risk groups. Those who are most likely to die by suicide on the railway are also those most likely to die by suicide in general: men in their mid-years of lower socio-economic position. Thus in September 2010, Samaritans launched a campaign to get 'men talking about their feelings', either through Samaritans' confidential helpline, or to family, friends, colleagues or professionals (Samaritans, 2010a). Samaritans undertook in-depth interviews with working class men in mid-life to develop the imagery and wording used in this campaign (see Samaritans, 2010b).

However, in talking to men from this demographic group, through discussions with experts[2] and from our own experience of suicide prevention and delivering our helpline, Samaritans began to ask some critical questions: Why are men in their mid-years in low socio-economic position more vulnerable to suicide than other socio-demographic groups? How is this group of men served by suicide prevention-related policy and practice? How effective are the messages commonly given to men by Samaritans and other suicide prevention organisations to 'seek help' and 'talk about your feelings'? Do men respond positively to these messages? Do they know how to 'talk about their feelings'? Does 'talking' help them? In order to provide some answers to these key questions, Samaritans initiated this report.

The research approach

Academic experts from across the United Kingdom and Republic of Ireland with different areas of specialisation were asked to draw upon evidence and theory in their area in order to explain why men in their mid-years in disadvantaged socio-economic positions, in the UK and ROI, are at greater risk of ending their lives by suicide; and to consider the implications for policy and practice (these five contributions are published in full in this report).

Key findings and themes from the expert reports were summarised and a 'model' was produced to explain the high risk of suicide in men in midlife in lower socio-economic position, drawing on ecological systems theory. On this basis, recommendations were developed for policy and practice to reduce suicide in this group.

Twelve case studies were undertaken by Volante Research and Samaritans research team with men from this socio-demographic group who have experienced suicidal feelings or behaviour, including men from each nation in the UK and from the ROI. The purpose of these case studies was to provide 'human stories' alongside the academic research (see the media report).

The research includes both fatal and non-fatal suicidal behaviour. For the purposes of this report, 'mid-years' or 'mid-life' is defined as the 30s–50s. It is recognised that this is a wide age range; experts were asked to consider variation within the age range, and to specify the ages to which evidence or themes included within their report refer. 'Low socio-economic position' is also used as a broad term, which can be defined and operationalised in many ways, including: economic position (e.g., being unemployed or economically inactive), occupational status (e.g., routine and manual occupations), income level (e.g., living in poverty or with a low income), housing tenure (e.g., living in rented accommodation) and educational attainment (e.g., without formal qualifications)

(Platt, 2011). The research seeks to understand suicide in the UK and ROI; however, literature examining other relevant socio-economic and socio-cultural contexts, i.e. western post-industrialised nations, was considered.

How to explain suicide in men of lower socio-economic position in mid-life

The causation of suicide is complex and multi-faceted; a broad bio-psycho-social understanding is required. In this report, the importance of psychiatric illness as an underlying factor in the majority of suicides is taken as given. But while an underlying factor in most suicides is psychiatric illness, most people with psychiatric illness do not take their lives. In order to explain the elevated risk among men in their mid-years of lower socio-economic position, the key challenge is to identify non-psychiatric factors that interact with psychiatric vulnerability. This report explores the increased risk of suicide in this socio-demographic group from a variety of perspectives, and connects death by suicide to the wider experiences of this group of men in society during the present historical period. This approach also emerges from critiques of the failure of suicide research and prevention to address suicide as a social issue, as follows.

There is ample evidence of systematic inequalities in suicide risk associated with different indicators of social position, including labour market status, occupational social class, education, income, housing tenure, and labour market position, at the individual level; and socio-economic deprivation at aggregate level. However, there has been a "near universal failure to consider equality issues in both academic reviews of approaches to suicide prevention and the formulation of national suicide prevention strategies" (Platt, 2011, p. 211). This is despite the recognition by governments of the importance of addressing health inequalities.

Suicide tends to be conceived in national strategies primarily as a health problem rather than a social problem. This is in part because suicide prevention strategies are based almost exclusively on biological, psychiatric and epidemiological research, largely using quantitative methods. As a result, what is viewed as significant in causing suicide are risk factors defined at the individual level (e.g., having a mental health problem, self-harming). Consequently the ways of combatting suicide seen as most appropriate are those which address deficits or risk factors in an individual (e.g., medication, therapy), rather than the social, economic or cultural context. There is considerable evidence of the associations between suicide and both socio-economic and psychiatric antecedents. "However, the social explanations are often subsumed in the pathological" and there is a need for "a more nuanced approach to the social factors that contribute to people feeling as though they wish to die" (Fincham et al., 2011, p. 175). In taking forward suicide prevention, it is important to consider how policy and practice might be informed by research from other disciplines and methods, in particular, research from a socio-economic or cultural perspective (Fincham et al., 2011, p. 172–177), and using qualitative methods.

An example of the limitation of the current conceptualisation of significant factors in suicide is the definition of high risk groups found in suicide prevention strategies in the UK and the ROI. High risk groups tend to be based on a single characteristic or factor, in accordance with the degree of risk associated with this factor or characteristic relative to the general population. Suicide strategies have identified as a priority or high risk group men under 50, or 'young (adult) men', but have failed to highlight the fact that it is men of low social position that are at greatest risk. Thus strategies do not recognise that it is men within a specific social, economic and cultural context who are at high risk – partly because of this social, economic and cultural context, and their socially-defined identities. As a result, the development of responses that engage men, address their specific needs and challenges, or the gender, social and economic systems that generate their high risk of suicide, is constrained.

Despite the fact that many more men than women kill themselves, the study of suicide and suicide

prevention has paid little regard to sociological theories of gender and masculinities. Suicidology recognises being male as a significant risk factor, yet tends to regard male and female as different but homogeneous sex groups (Scourfield, 2005) and to "treat gender as a descriptive, rather than causal, factor in suicidal behaviours" (Payne, 2008, p. 23).

Much attention has been focused on suicide and other 'troubles' in young men: they are more visibly problematic to society than men in mid-life, in part because of the socially disruptive ways in which they 'act out' (McDowell, 2000; Scourfield, 2005). As middle-aged men are "less likely than their sons to riot in the streets, they attract relatively less media attention" (McDowell, 2000, p. 207). Some have argued that the vulnerability of young men to suicide is generally exaggerated and that "'insufficient attention is paid to the diverse social circumstances of suicidal men and women" at different ages (Shiner et al., 2009, p. 738). Mid-life is under-researched in general, and the available studies on men in mid-life tend to focus in isolation on one aspect of men's lives, such as help-seeking, or health-related behaviours (Fincham et al., 2011).

A note on women, ethnicity and sexualities

It has been said that the focus on rates of death by suicide "masks the fact that suicidal thoughts...self-harm and suicide attempts are all higher in women than men" (see Scourfield, 2005).[3] Nonetheless, the fact remains that it is men who die far more by suicide than women. To reduce death by suicide, targeting the highest risk groups is key; thus, men in their mid-years of low socio-economic position are the focus of this report.

A complete gender analysis would entail examining the commonalities and differences in pathways to suicidal thoughts and behaviour between men and women; understanding why fewer women who think about or attempt suicide go on to die by suicide (compared to men) might contribute to understanding the higher risk of suicide in men. This may be an important avenue for future research, but is beyond the scope of this report. Giving focused attention to this group of men does yield important insights.

This report has chosen not to focus on the role of ethnicity or sexualities in suicidality. The situation of men in their mid-years in lower-socio-economic positions who are from black and minority ethnic (BME) groups, or with lesbian, gay, bisexual, transgender (LGBT) or other sexualities, will be complicated by also occupying these 'subordinate' positions. There is concern about 'equalities groups' in suicide prevention and research, and this is important.[4] However, examining the experiences and identities of British and Irish middle-aged working class men, the majority of whom are white and heterosexual, is core to reducing death by suicide.[5]

In research, policy and practice to address suicide in this group of men, it is important to remember that, while they may be marginalised in power structures by social position – for example, relative to middle-class men (and sometimes women), they may also be implicated in the subordination of other groups, of women and men, including BME or LGBT groups. The needs of disadvantaged men in their mid-years must be addressed, but in ways which benefit society as a whole (Ruxton, 2009; Wilkins, 2010; European Commission, 2011).

Summary of findings

This section provides a summary of the findings from the expert reports,[6] arranged largely according to the material covered by each report. There is inevitably some overlap in the ground covered by the different reports, but this is retained in the summary to keep the coherence of the arguments. The summary begins at the individual level, and moves outwards to macro-social and economic processes.

Psychological and personality factors

Psychological factors that increase the risk of suicidality

There is a strong association between mental illness and suicide risk. However, it is important to identify the specific psychological factors or mechanisms which increase the likelihood that someone will develop suicidal ideation; and to differentiate between those who develop suicidal ideation but do not attempt suicide from those who do go on to engage in suicidal behaviour. This line of enquiry is necessary in order to improve identification of, and intervention with, those at greatest risk of completing suicide, as well as to develop psychological therapies to address the specific psychological factors that lead to suicidal behaviour (Johnson et al., 2008; O'Connor, 2011).

There is empirical evidence of several psychological and personality factors which increase risk of suicidal ideation and behaviour. These include:

- social perfectionism (the perception that one must always meet the expectations of others, with these perceived standards often being unrealistic);
- self-criticism (excessive negative self-appraisal and an inability to enjoy one's own successes);
- rumination (frequently recurring, persistent self-focused thoughts – in particular brooding rumination: comparison of one's current situation with some unachieved standard, without doing anything to pursue the outcome one desires);
- reduced social problem-solving ability;
- an inability to generate positive future thoughts (it is lack of belief that the future includes positive events, rather being overwhelmed by negative expectations of the future, which is significant for suicidality);
- lack of goal re-engagement (failure to re-engage in new goals when likelihood of achieving existing goals is remote);
- feeling defeated and trapped;
- thwarted belongingness (feelings of social disconnection and isolation);
- perceived burdensomeness (the belief that one is so incapable that one is a liability or hindrance to others);
- impulsivity, pain sensitivity (threshold and tolerance for physical and emotional pain) and acquired capability for suicidal behaviour (ability to act upon suicidal desires or to enact lethal self-injury, and increases via exposure and habituation to self-injury).

Psychological model explaining suicidal ideation and behaviour

The Integrated Motivational-Volitional (IMV) Model[7] seeks to integrate the various psychological, biological and social factors associated with suicidal behaviour into a model which explains and predicts the development of suicidal thoughts and when these will progress to action. The model has three phases, and postulates that the presence of particular psychological, biological and social factors increases the likelihood of moving through the phases:

Pre-motivational phase: background factors and triggering events

Biological or personality factors, or life experiences (e.g., socio-economic deprivation) make an individual vulnerable; the individual then experiences a 'triggering' event (e.g., relationship crisis). Significant personality traits include social perfectionism and self-criticism.

Motivational phase: formation of suicidal ideation and intentions

The next phase builds on the 'arrested flight' model of suicidal behaviour. An individual experiences defeat and/or humiliation where they fail to attain an individual or social goal. When the desire to escape from the defeating and/or humiliating situation is thwarted, the individual may develop feelings of entrapment. From the experience of entrapment, suicidal feelings may arise. Importantly, this can be as much about an individual's perception as the objective characteristics of the situation.

Psychological factors such as reduced problem-solving ability and brooding rumination increase the likelihood that feelings of defeat will progress to feelings of entrapment. The individual becomes absorbed in repeatedly dwelling on their failure, comparing their current situation with some unachieved standard or outcome, without seeking to solve the problem, and feels trapped, unable to escape from the actual or psychological defeat.

Feelings of entrapment are more likely to progress to suicidal thoughts and intent in the presence of factors such as thwarted belongingness, perceived burdensomeness, low levels of actual or perceived social support, and lack of positive future thinking and goals. The person perceives the future as holding nothing for him or her; s/he has no goals to strive for, believes that s/he is alone and does not matter, and that nothing and no-one can change his/her situation.

Volitional phase: suicidal behaviour

The third phase, drawing on the 'theory of planned behaviour', helps to explain why some people act on their suicidal thoughts (by attempting suicide) and others do not. According to the model, the presence of 'volitional factors' increases the likelihood that a suicide attempt will occur. For example, a key factor is a suicide plan: suicide becomes more likely (perhaps in response to a critical situation) when a detailed plan is developed, including when an individual will attempt suicide, where that will be and the method they would use. A second factor is acquired capability for suicidal behaviour, the ability to enact one's plan or intentions. Other factors include pain sensitivity, impulsivity, imitation (of suicidal behaviour in others) and access to the means to end one's life.

Psychological routes to suicide in men

Unfortunately, there is a dearth of research exploring effects of age, gender and socio-economic status upon the key psychological and personality antecedents of suicidal behaviour. Those in middle-age are a neglected population within psychological research, and there is a lack of literature investigating the psychological route(s) to suicide in men in their mid-years in low socio-economic positions.

However, there is evidence that males engage in more risk-taking behaviour and have a higher threshold for, and tolerance of, pain than women, which may lead to increased capability for suicidal behaviour (and use of more lethal means when engaging in suicidal behaviour). In addition, making risky choices under stress – such as drinking more heavily or making rash financial decisions – can lead to an increase in life problems, which could increase suicide risk. Unemployed males display higher levels of social perfectionism and also generate fewer effective solutions to social problems compared to men in work or training; these psychological factors are linked to suicidality.

Masculinities

Sociological understandings of gender

'Masculinity' and 'femininity' are sociological concepts which can be defined as the collection of roles, behaviours, activities, expressions and practices that are broadly associated with being male or female, respectively. In this view, men's and women's identity, behaviour and the expectations placed on them are not purely the result of their biological sex, but reflect socially constructed ideas about 'being a man' or 'being a woman'.

There is variation in the way 'masculine' and 'feminine' are defined across different social settings or contexts, so it is more appropriate to use the terms 'masculinities' and 'femininities' (plural). 'Hegemonic masculinity' refers to the current form of masculinity held in highest regard in a particular social context; it is an ideal to which most men aspire and/or against which they measure themselves. In general, hegemonic masculinity is characterised by attributes such as: striving for power and dominance, aggressiveness, courage, independency, efficiency, rationality, competitiveness, success, activity, control and invulnerability; not perceiving or admitting anxiety, problems and burdens; and withstanding danger, difficulties and threats (Möller-Leimkühler, 2003, p.3).

In gender relations there are inequalities not just between groups of men and women, but also between different types of masculinity. Hegemonic masculinity is the most desired and powerful form of masculinity; complicit masculinity describes the gender relation of men who benefit from the 'patriarchal dividend' (i.e. they benefit from men's general dominance and higher status within society) without achieving hegemonic masculinity; marginalised masculinity refers to gender relations experienced by men where their gender intersects with other structures, such as class and race (Connell, 2005; Meth & McClymont, 2009). These are dynamic categories: an individual may move between 'masculinities' in different contexts.

Men of low socio-economic position occupy marginalised masculinities related to class. However, these masculinities can also be complicit in seeking to exercise patriarchal power, for example, over women and children.

Masculinities and economic position

Employment is an important aspect of hegemonic masculinity through its association with independence, self-sufficiency and the 'provider' role. Men in mid-life invest in work/employment as a way of constructing their masculine identity. Being unemployed at this life-stage is deeply distressing, since it undermines men's own expectations of stability and security; men without work lack an important source of valued masculine identity.

As a result of changes in the nature of employment and the labour market, in particular the 'feminisation' of employment (shift towards a more service-oriented economy) and the loss of jobs requiring heavy manual labour, men in lower socio-economic groups now have less access to jobs that allow for the expression of working-class masculinity, and have thus lost a source of masculine identity and 'pride'. Working class men may struggle to 'reconstruct' their identity to fit the changing labour market situation. They may not take up jobs that do become available within the service economy because these conflict with their working class masculine identity.

Providing for the family

Men may experience unemployment in mid-life as a double failure, since they are unable to meet two central demands of the masculine role: being employed; and 'providing' for the family. One explanation for the lower suicide risk among women is their greater involvement in childrearing and the higher societal recognition/status accorded to their role as mother (compared to the role of father). Despite changing discourses of fatherhood, working class men still consider providing for the family as most important, with the hands-on work of caring for children seen as non-masculine.

Constricted by masculinity

Overall, for many working-class men, the hegemonic role is narrow and constraining. Their low socio-economic position makes them more vulnerable to being unable to meet the demands of the masculine worker and parent roles in the mid-life stage. Men who are unemployed or experiencing financial difficulties may be at greater risk of depression (and other mental health problems), relationship breakdown, social isolation, alcohol and drug use, and suicide.

Bodily expressions of masculinity

Bodies are prime sites for signifying or performing gender identities. Hegemonic masculinity might be enacted through dressing, moving or behaving in particular ways. In general, masculinities are closely related to a variety of physical, bodily concerns, including 'risky' and harmful bodily practices, having a 'cavalier' attitude towards bodily health, and avoiding or delaying help-seeking. Many of these damaging practices are particularly associated with working class subcultures. Suicide can be conceptualised as the ending of the 'self' through enactment of a range of these practices to an extreme degree.

Alcohol and drug use

In the context of suicidal behaviour, especially among men, alcohol and drug use are the most widely discussed damaging bodily practices. There is a strong association between substance misuse and unemployment and lower socio-economic status on the one hand, and suicidal behaviour on the other. While excessive alcohol use is found among men in all social strata, the prevalence of alcohol-related harm (e.g., alcoholic liver disease) is higher in lower socio-economic groups. Alcohol use is a normalised part of everyday life for working class men and an aspect of masculine expression. Men are more likely to 'self-medicate' with alcohol (and drugs), using substances to manage their emotions and their (particularly depressive) symptoms and avoiding 'help-seeking' (from both informal and formal sources). Substances are seen to be a 'masculine' way of coping, in contrast to more 'feminine' methods, such as seeking help or talking to people. It should also be noted that excessive alcohol and drugs use may increase impulsivity and reduce inhibitions, resulting in an increased likelihood of suicidal behaviour at a time of crisis.

Masculinity as driver of suicidal behaviour

It has been proposed that some aspects of hegemonic masculinity could be health-damaging, even to the point of propelling men towards suicidal behaviour. Hegemonic masculinity is associated with emotional control and power, while depression is more often linked to powerlessness and a lack of control over emotions. Thus, suicide has been conceptualised as a way of expressing or regaining control in the face of depression. For some men, suicide is incorporated into a version of an 'in control' masculine identity. Men's greater use of lethal methods to complete suicide can also be seen as an expression of masculinity and men's understanding of appropriate masculine behaviour. 'Failure' to succeed in taking one's life is associated with the more 'feminine' practice of self-harm and therefore to be avoided as a potential (additional) source of shame.

Relationship breakdown

Causal association between relationship breakdown and suicide

There is considerable research evidence of an elevated suicide risk among divorced and separated persons compared to those who are married. While results are not consistent, this elevated risk appears to be greater for males compared to females. In addition, divorced males have been shown to have higher levels of suicidal ideation than divorced females, and separated men are twice as likely as separated women to have made plans about ending their lives. A comparison of suicide risk for separated or divorced men across the lifespan found that, in four out of six studies, mid-life

(30–64 years) was a more important risk factor than younger adulthood. No evidence was found for variation in the association between relationship breakdown and suicide risk by socio-economic status and gender.

There is sufficient evidence for a causal association between relationship breakdown and suicide risk. However, we should note the possibility that some of this association may be accounted for by matrimonial selection (i.e., those who enter marriage are less likely to be mentally unwell than those who are not married, and those who stay in marriage are more likely to be mentally well).

Why relationship breakdown contributes to suicide

Explanations for the association between relationship status and suicide tend to be based on Durkheim's concept of social, particularly domestic, integration, which proposes that marriage (or settled relationship) can diminish the risk of egoistic suicide (caused by an excess of individuation and a lack of connectedness to others in the family and wider community), since it offers the individual a source of regulation and a sense of meaning. More recent research suggests that marriage is a protective factor, enhancing wellbeing, reducing exposure to stress, providing a source of social norms and meaning, and increasing access to social networks. Divorce increases the risk of suicide because the individual becomes disconnected from their domestic relationship and social norms.

In addition, within western societies there is a strong cultural emphasis on achieving a strong and happy marriage, and those who divorce may experience a deep sense of disorientation, shame, guilt and emotional hurt. The sense of shame may be particularly important; separated males and females who experience suicide ideation have higher levels of internalised shame than separated individuals who are not suicidal.

Why relationship breakdown has a greater impact on men

Various explanations of the differential impact of relationship breakdown on suicide risk among men and women have been proposed.

First, **men derive more benefit from marriage than women**, and marriage entails more emotional distress for wives than for husbands. Wives report more psychiatric disorders than husbands, whereas men tend to have higher levels of distress and psychiatric disorders in the unmarried population. The 'new man' who shares responsibilities with women is more of an idea(l) than a reality, with most men still expecting to be taken care of in intimate relationships.

Second, **traditional constructs of masculinity** cause problems for men's mental health, especially those of lower socio-economic status. Men's social roles are more inflexible than women's, with more pressure on men to conform and thus more negative psychological or social consequences for men who fail to attain conventional masculinity. There is a large and unbridgeable gap between the culturally authorised idea of 'hegemonic masculinity' and the reality of everyday survival for men in crisis. Honour is part of masculinity, and requires public affirmation and validation before other men. Loss of masculine status through relationship breakdown results in a sense of shame. For some men, a life of shame and dishonour is seen to be a life not worth living.

Third, men are less able than women to meet the **changing expectations for increased intimacy** in marital relationships. The interdependence of the 'pure love' relationship is incompatible with the self-sufficiency that men, especially of lower socio-economic status, expect of themselves. Men may develop unrealistic, idealised expectations of relationships, while not having the emotional skills to negotiate the complex reality of relationships or cope with emotional distress, which may result in an intense, self-destructive reaction to relationship breakdown.

Fourth, despite the fact that actual practices of fathering may not have significantly changed, there is an increased cultural emphasis on men as involved fathers. When marital relationships fail, men are less likely to be awarded custody of, or have access to, their children. **Separation from children** appears to be a significant factor in some men's suicides. In addition, men are more likely to be displaced from the family home, to unstable accommodation or homelessness, itself a risk for suicide.

Fifth, **actual or attempted control of partners** is found in many male suicides that are triggered by relationship breakdown, and this needs to be placed in the context of men's controlling behaviours in intimate relationships and domestic abuse. Such suicides include impulsive reactions to ex-partners beginning new relationships or acts designed to punish ex-partners.

Sixth, men tend to experience greater **loneliness** than women, even where they are not socially isolated. Their social networks are less supportive and they have fewer meaningful friendships.

Relationship breakdown and socio-economic status

Many suicidal acts occur in the context of a cluster of difficult circumstances that compound each other. For men living in materially difficult circumstances or experiencing unemployment or debt, the impact of a relationship breakdown may be more severe; and economic pressures can contribute to relationship breakdown. For men in lower socio-economic groups, relationship breakdown can result in deterioration in economic status (e.g., loss of housing, debt or unemployment), itself a risk factor for suicide, while also further increasing the gap between everyday reality and the culturally authorised ideal of 'hegemonic masculinity'.

Emotional lives and social (dis)connectedness

The big build

The inability to express distressing emotion is considered to be a risk factor for suicide. Compared to women, men tend to have less awareness and ability to cope with their own emotions or the emotions of others. This lack of emotional knowledge is part of the construction of masculinity, rooted in beliefs developed from childhood, that to disclose – or even experience – emotional distress constitutes weakness. Not having been socialised in emotional skills, some men may then not have opportunities to develop such skills in mid-life. The result may be a 'big-build' process: emotional illiteracy hinders men from identifying their own emotional distress; such feelings build for some time before men realise they are vulnerable; they may then feel inhibited about admitting these problems to others or seeking help; and, as a result, experience a build-up of distress which can culminate in crisis, including suicidal feelings and behaviour.

It's good to talk?

Some academics suggest British culture is shifting to increased disclosure about emotional lives, where 'talking about feelings' becomes a moral imperative. Regardless of changes in actual emotional practice, there is a widespread perception in Britain that emotions are now more freely discussed than in the past. However, those born before the second world war are more sceptical about the value and importance of talking about one's feelings. Some have argued that there has been a move to androgenisation – that women and men have become more similar in their emotional expression. However, most empirical studies show that women continue to be much more positively orientated to 'emotions talk' than men, across all ages and classes.

Men currently in mid-life have lived through a changing emotions culture. They are aware of the 'good to talk' cultural imperative but are uneasy

about behaving accordingly. There is some evidence that middle class men are better at 'talking the talk' – talking about their feelings as a way of gaining approval in relationships. However, there is little difference across social groups of men in their attitudes to emotions talk or the frequency with which they actually talk to those close to them. In terms of men's beliefs about emotions talk, what matters most is not social class, but gender and generation (see below). Thus, when thinking about the significance of class, it may be better to focus on the way socio-economic vulnerabilities place men of lower socio-economic position at risk of suicide, rather than on less prominent class differences in the emotional skills of men.

Dependence on women

Personal relationships have a powerful effect on health and wellbeing, including mental wellbeing. Research shows that webs of informal emotional support continue to play a major role in the lives of the majority of the population. Most people have other people around them with whom they would talk if feeling worried, stressed or down. However, the relative narrowness of emotional connections among men in mid-life leaves some men vulnerable to emotional distress, mental health problems and suicide, when faced with negative life events.

Women are more prominent than men in men's (and women's) accounts of others 'being there' for them – as mothers, partners, daughters, siblings and friends. Women, across age groups and classes, maintain a key role in men's emotional lives. Who people turn to is not constant across the life course, and this is particularly affected by processes of partnering and de-partnering. Men in mid-life are overwhelmingly dependent on their partner for emotional support – to a far greater extent than women of the same age. Women tend to maintain close same-sex friendships across their lives, while same-sex friendships drop away for men over 30. However, men may choose not to share with wives or partners because they wish to protect and not worry them, and because they believe women want 'strong masculinities'.

When relationships break down, men face the loss of their primary emotional relationship, without other social connections to fall back on; and, if they are unemployed, they will also be without work-based companionship. Further, they may perceive themselves to be without support; and perceived support can be as significant as actual support in its negative impact on (mental) health and wellbeing.

Friendships with men

While frequently fearful that male friends will find out about their distress, men do describe emotionally significant friendships, although they do not necessarily talk to these friends about emotional issues on a regular basis. Relationships between men tend to be concerned more with 'doing' and 'being alongside' than the self-revelation and nurturance of women's friendships. Men's friendships should not be judged as without value because they do not follow the same 'script' for intimacy as women's. There are times of crisis when men do speak to particular male friends. Where emotional talk does take place between men, it is often presented as spontaneous. For the most part, however, activities such as listening to music or exercising are more to the fore than talk in men's accounts of 'healthy' ways of managing stress or worry.

What counts as support

When asked what counts as emotional support, many men (and women) do not describe relationships based primarily on 'talking about feelings'. What counts as support is 'being there', 'being alongside' and understanding/empathy, based on personal experience, or knowledge of the person, and being reachable if needed. Men describe seeking out those in their network who are perceived to be non-judgemental and who, crucially, know them and the background to the stories they are telling. They seek, in other words, unconditional acceptance, summed up by the phrase "no questions asked" – and this includes permission not to talk about problems or losses. What also matters is that this talk goes no further; that the listener will neither ask questions nor repeat what they have heard to others.

Therapy or counselling

Use of formal talk-based support (psychiatry, psychology, counselling or therapy) is relatively rare in the British population, although a significant proportion of all adults have consulted their GP when they felt worried, stressed or 'down'. Men are much less likely than women to have a positive view of accessing formal support for emotional difficulties, in keeping with their general ambivalence about emotions talk. However, the gender gap in actual use of talking therapies is less wide, suggesting use is associated with actual need, i.e., the experience of significant mental health problems, which is evenly spread across men and women in mid-life. Use of formal emotional support remains primarily associated with moments of crisis and the failure of usual support mechanisms. Thus, the problem is not so much how to persuade men to use formal support at times of crisis, but how to build their ability to access informal and formal support in advance of those points of breakdown, before the 'build-up' begins.

There is a better understanding of therapy/ counselling and how to access such services among better educated and more affluent men; however, lack of belief in the efficacy of talk is common among men of all socio-economic groups. There is a strong relationship between mental ill-health/wellbeing and measures of social class and income, so one might expect higher levels of service use among poor people. However, this is not the case; there is evidence of the substitution of a pharmaceutical response for a talk-based response to mental health problems among the most disadvantaged sectors.

Men in their mid-years today

Defining mid-life

Men in their mid-years today are impacted by historically specific cultural, social and economic processes, which influence their identities, experiences, relationships and emotional lives; and form the context of their suicidal acts. 'Middle age' tends to be defined in terms of chronological age, but its precise boundaries are blurry and change over time. As longevity has increased, the middle phase of life has become extended, and distinctions have begun to be made within mid-life – between 'early' and 'late mid-life'. Age and life stage interact with generational position (relations between child, parent and grandparent) and cohort (a population that experiences the same significant events at a given time) effects. The shared experiences of a cohort can lead to an ideologically distinct group, with a generational identity (although this may well contain opposing groups). Interacting with these chronological, cohort and generational positionings are period effects, for example, the current economic crisis. Age, period, and cohort influences are not easy to disentangle. The experiences, beliefs and behaviours of men in their mid-years today reflect their time (cohort and period), their parents' beliefs (generation) and the cycle of life.

Mid-life as life stage: the bottom of the U curve

Mid-life has traditionally been viewed as the prime of life. However, there is mounting concern among mental health practitioners and policy makers about the apparent dip in subjective wellbeing and strong evidence of mental ill-health in this age group in general. Subjective wellbeing, for both men and women and across all socio-economic groups, currently follows a curvilinear age trajectory – a U curve – with subjective wellbeing lowest during the mid-years.

Several models could be drawn on to explain the higher risk of suicide at this stage of life. The social investment model, for example, understands mid-life as a time when the consequences of long-term decisions about work and relationships come to light. This is also the time when the possibilities for making changes in these domains are limited, and likely to come at a high cost, resulting in risks to men where their investments in relationships or work break down. The current middle-aged cohort is the largest ever, and, given this size, men in this cohort find themselves in competition to meet the life-stage demands of work and relationships – a situation that is exacerbated by the current economic crisis.

Another explanation is the social drift hypothesis, in which chronic mental illness, including alcohol abuse (which escalates over time), culminates in mid-life. The social genesis model looks at the serious consequences of cumulative spells of unemployment for those in mid-life, particularly those with few or no qualifications.

Mid-life as generational position: the 'sandwich' generation

Most people in their mid-years today have family that spans several generations, giving rise to the so-called 'sandwich' generation – those who are simultaneously caring for their children and possibly grandchildren, as well as their elderly parents, and/or those who care for dependants and also work. While it is still predominantly women who care for younger and older generations, men are often part of this increasingly complex equation of balancing work and care, with implications for the demands on, and support available for, men.

Kinship contact remains greater for working- than middle-class families. In working-class communities, close knit networks can be key to survival at times of financial hardship, but can also intensify inter-family conflict.

The middle years as a cohort: the 'buffer' generation

There is evidence for a clear break between pre- and post-war generations in terms of how they manage their emotional lives and their attitudes to support services – the difference between the pre-war 'silent' and the post-war 'me' generation. In this context, the notion of the 'buffer' generation, the generation caught between more traditional and progressive cohorts, helps make sense of the ambivalent emotional (and other) practices of the current cohort of men in their mid-years. Men find themselves caught between new identities and the pull of the older classed masculinities of their fathers.

Experience of significant social change

Since the 1970s, several important social changes have impacted on the current mid-life cohort's personal lives, including increases in female employment, births outside of marriage, divorce and cohabitation, lone parent households, second and subsequent marriages, and step-families and solo-living.

Some have argued that these shifts signal a changing gender order, which has been linked to mental health problems in men, the so-called crisis of masculinity thesis. Some commentators also see these shifts as part of processes of individualisation. That is, relative to previous generations, who found themselves bound by traditions and social structures, there is now greater individual choice in negotiating our own biographies. These arguments have been criticised, however, for underplaying the extent to which constraints, including socio-economic location and traditional constructs of gender, continue to shape our lives.

One area of significant social change for men's personal lives is the increase in men living alone in mid-life. Fewer middle-aged men than women were living alone in 1984, but by 2007, men had caught up. Among people of working age, men are more likely than women to live by themselves. Of those men who do live alone, most have been in a co-residential partnership at some stage, a significant minority have been in multiple partnerships, and a significant proportion have non-residential children. So-called 'absent fathers' have been linked to the rise in lone parent families and divorce or separation; when fathers come to live in different households, there can be a reduction in contact with children. The 'never partnered' middle aged men are considerably more economically disadvantaged than their female counterparts, though this finding relates mainly to those men in later mid-life. Analysis of Scottish Household Survey data suggests that rates of solo-living are higher among middle-aged men who are socially and economically disadvantaged, and that they are also more likely to live alone than are women of the

same age in the same areas.

While living alone does not equate with being lonely, there are aspects of living alone which suggest that men in this position are at a disadvantage: they are less economically active, with a significantly larger proportion permanently sick or disabled; more likely to report poorer health, and to smoke and drink; and more likely to have lower access to home ownership and higher use of social housing. Crucially, men living alone may also have less access to informal care and family support; despite often being sociable, they are less likely than their peers to have anyone with whom they can discuss personal matters.

Socio-economic position

Low socio-economic position increases suicide risk

The relationship between socio-economic factors and suicidal behaviour has been subject to extensive empirical exploration. Variables that have been investigated include employment status, income, occupational social class, education (at an individual level); and economic growth/recession, unemployment rate and income inequality (at the aggregate level). The balance of evidence suggests that, controlling for other risk factors (including the presence of mental illness), unemployment, low income, socio-economic deprivation and economic recession increase suicide risk. Membership of a low socio-economic group in itself increases the risk of suicide.

Employment

There is evidence that unemployment has a direct causal effect on suicide, as well as contributing to a variety of other health and social consequences which contribute to suicide (Platt, 2011). With regard to employment status, several (but not all) cross-country studies report a positive and statistically significant association between unemployment and suicide after controlling for other relevant variables (confounders): higher unemployment rates tend to be associated with higher suicide rates. Individual-level studies suggest that those who are unemployed are two or three times more likely to die by suicide than those who are in work. When trends by gender are examined, the findings are unclear. Some studies find little or no gender difference, while some report that the impact of unemployment on suicide is greater in females. The few studies that have examined age differences tend to show a stronger impact of unemployment on suicide risk among younger (rather than older) adults.

Income

Research on the relationship between per capita income and suicide at the country level shows inconsistent results. Some studies demonstrate that a higher GDP per capita is associated with a lower suicide rate, even after controlling for a range of other socio-economic variables. Other studies, however, have found the opposite: higher income levels are associated with a higher suicide rate. One study reported different associations by gender: per capita GDP was positively related to the female suicide rate, but negatively related to the male suicide rate.

At the individual level, a US-based study found that suicide risk declines as personal income increases, but (holding own income constant) suicide risk increases as county income increases. One Danish study reported a U-shaped association between income and suicide risk: the risk was highest in the lowest income group and lowest in the middle-income groups. Another Danish study found that suicide risk increased with declining (individual) income levels. These associations were stronger in males than females and among younger compared to older adults.

Occupational social class

Variation in suicide rates by occupational social class have been explored in several British studies. One influential study examined suicide deaths by age, economic activity status and social class in men of working age in England and Wales. It found a significantly elevated risk among men in semi- and un-skilled manual classes compared to skilled

manual workers and non-manual social classes. There is evidence of both a step-change in risk between non-manual and manual social classes and a gradient between non-manual social classes (considered as a whole) and each successively lower manual social class. The study also found a significant interaction between age and social class, with particularly high suicide rates among those aged 25–44 in the lowest social class (unskilled manual workers). Other research confirms the excessive suicide risk among those in the lowest occupational social classes.

Education

Other variables, including education, housing tenure and car access, have been used to assess the relationship between socio-economic status and suicide. One study examined the relationship between education level and suicide among men and women in 10 European countries. The suicide rate among men was higher in the group with a lower educational level in all countries. The difference was particularly marked in England and Wales, where men with the lowest level of education had more than 2.5 times the risk of those with the highest level of education.

Inequality

Examination of the relationship between income inequality and other measures of income distribution and suicide rates has produced mixed results. In cross-country studies, some researchers have found a positive association, while others have failed to find a statistically significant association. A systematic review of within-country analyses of the association between area-based socio-economic characteristics and area-level suicide rates found that a majority (55%) of studies reported no significant association, 32% reported a significant negative relationship (areas of lower socio-economic status tended to have higher suicide rates) and 14% found a significant and positive relationship.

Area-level effects

Exploration of the nature of area-level effects, where present, suggests that the personal characteristics of area residents (composition) are more important than the characteristics of areas per se (context), although evidence of the influence of the latter can be found (Platt, 2011). The socio-economic structure of an area may affect suicide through behavioural cultures and psycho-social mechanisms.

Economic recession

The association between economic recession and suicide has been explored in several studies. Contrary to the evidence of a procyclical effect for all-cause mortality (mortality tends to decline during periods of economic recession), there is evidence that suicide incidence increases during recession. One recent study examined the impact of unemployment on suicide rates in 26 EU countries between 1970 and 2007. It was found that, for every 1% increase in unemployment, there was a 0.79% rise in suicides at ages younger than 65 years. Larger increases in unemployment (more than 3% in a year) were associated with even larger increases in suicide (about 4.5%). The effect of unemployment was positive but insignificant for men aged between 45 and 59 years and positive and significant for men aged between 30 and 44 years. One explanation for this finding is that worsening economic conditions may have a negative effect on mental health at a population level.

Why does low social position increase suicide risk?

Why low social position increases suicide risk is a much debated topic (Platt, 2011). Some of the attributes of low socio-economic position that may lead to increased suicide risk in an individual include: accumulated lifetime adverse experiences (e.g., health, employment, living conditions); powerlessness, stigma and disrespect; experiencing other features of social exclusion (e.g., poverty, poor educational attainment); living in socio-economically deprived areas; poor mental health;

and unhealthy lifestyles. Factors that might create a context which increases suicide risk include: physical (e.g., poor housing conditions); cultural (e.g., tolerant attitudes to suicide); political (e.g., adverse local public policy); economic (e.g., lack of job opportunities); social (e.g., weak social capital); history (e.g., high suicide incidence); infrastructure (e.g., poor quality, accessibility, acceptability of services); and health and wellbeing (e.g., high prevalence of poor general and mental health) (Platt, 2011, p. 299–230).

Feminisation of labour

Unemployment in the UK is higher among men than women. This is related to the decline of predominantly male types of employment, such as manufacturing, and the growth of predominantly female types of employment in services. 'Irregular' types of employment (such as part-time and temporary work) have been growing and have been taken up more by women than by men. While almost half of all women work part-time, there has also been an increase in full-time jobs for women. There are geographical patterns of unemployment and incidence of workless households in the UK associated with the big cities in the north of England and Scotland, largely attributable to the contracting manufacturing base, and affecting men in particular. Further, the ratio of unemployment among unskilled workers to the standard unemployment rate in the UK has been high within the European context. Men have also been affected by the general trend towards irregular work patterns, insecure or temporary work and self-employment (Clasen, 2000).

The popular narrative is that men have been disadvantaged by the increased ascendency of women in the job market. However, women are generally more poorly paid, promoted more slowly and far less likely to pull the real levers of power and decision-making than men. In addition, there has been a more general exclusion of men and women of low social class from the labour market (McDowell, 2000). In European countries, a polarisation has developed since the early 1980s between work-rich, two-earner households and workless (no earner) households, while the share of mixed households has been declining. Today, in over 60% of all households in the UK, all adults are in work. By contrast, almost 20% of all households (with adults of working age) do not contain anybody in paid employment (Clasen, 2000, p. 4–5).

Economic crisis

Currently, the UK and ROI are experiencing a significant economic crisis. For many, the most salient feature of this crisis is the growth of unemployment. There has been a dramatic increase in unemployment in Ireland for the population as a whole (from 4.6% in 2007 to 14.4% in 2011) and for men in particular (from 4.9% to 17.5%); female unemployment in Ireland increased from 4.1% to 10.6% during the same period. Overall unemployment in the UK increased from 5.3% to 8% between 2007 and 2011, with a slightly higher increase in the rate for males (5.6% to 8.7%) than for females (5.0% to 7.3%).

The impact of the financial crisis on suicide among men and women and in different socio-demographic groups is still unfolding. As yet there has been relatively little published research on the effect of the current recession on suicide risk, generally explained by the relatively recent onset of this recession and the delay in registering suicide deaths. Given the evidence outlined in this report, it is probable that the current recession will affect the suicide rate, and there is evidence emerging that this is the case.

A very recent paper (Barr et al., 2012) provides evidence linking the recent increase in suicides in England with the financial crisis: English regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men. The study finds that, between 2008 and 2010, there were 846 more suicides among men than would have been expected based on historical trends, and 155 more suicides among women. In addition, significant gender differences were found. Each 10% increase in the number of unemployed men was significantly associated with a 1.4% increase in male suicides, suggesting that about two fifths of the recent increase in suicides among men (increase of 329 suicides) during the 2008–10

recession can be attributed to rising unemployment. However, the study found unemployment rates were not associated with the increase in female suicide. The authors conclude:

"Overall, women seem less likely to inflict self harm in response to unemployment, suggesting an increased degree of resilience among women, which has been identified in other European countries. Our study may have lacked sufficient power to detect an effect in women, if this effect size was small. An enhanced understanding of the role of responses from each sex may help mitigate risks." (Barr et al., 2012, online, policy implications section, para. 1)

Explanation for the high risk of suicide in disadvantaged men in mid-life

This section uses the findings from the expert contributions to develop a 'model' which seeks to explain why men of low socio-economic position in their mid-years are at excessive risk of suicide.

Theoretical approach

In keeping with the dominance of medical, psychiatric and epidemiological paradigms in suicide research, models of suicidal behaviour tend to be ahistorical and universal – they seek to describe factors which, if present, should lead to suicide regardless of context. However, the model described below is intended to provide an explanation for why a socially specific group of men at this historical time are at excessive risk of suicide. It does this by drawing on Urie Brofenbrenner's ecological systems theory.

An ecological perspective looks at the interrelationships between individuals and their contexts and between micro-level (individual or local) and macro-level (societal) contexts; and the way that identical processes may have differing expression in different social contexts (Harney, 2007, p. 75; Darling, 2007, p. 203; Kidd et al., 2006). A person has direct interactions and relationships with their family, work, etc; these relationships influence each other (for example, a conflict at work may impact on family); and the contexts in which individuals live are affected by wider systems, such as welfare or health policy, and also by large socio-economic processes, such as economic recession. In addition, there are changes within time periods and through the lifespan that affect a person or their environment. Importantly, as individuals are influenced by those systems surrounding them, they also influence these systems through interacting with them (Newbury, 2011; Harney, 2007). Post-structuralist theorists have emphasised the importance of not seeing contexts, institutions or systems as surrounding or framing the person, but rather as constructing the individual: for example, hegemonic masculinity emerges from large social processes and structures, but constructs the identities of individual men, influencing how men think, feel and behave in everyday life (Newbury, 2011).

The full development of an 'ecological system' for suicide in men in their mid-years of low socio-economic position would require more empirical research. However, what emerges from literature surveyed for this report is the way in which large economic and social processes interact with low socio-economic position, life-stage/generation and masculinity in order to generate the excessive risk of suicide in disadvantaged men in their mid-years.

Suicide in disadvantaged men in their mid-years

Macro/'societal' influences

Over the last half century, significant 'large processes' in society have included:

- economic restructuring to a service economy, the decline of predominantly male types of employment such as manufacturing and the increased employment of women
- increased partnering and de-partnering, births outside marriage, divorce and cohabitation,

second and subsequent marriages, absent fathers, step-families, lone parent households and solo-living
- shifts from traditional 'silent' pre-war culture to the more progressive 'me' post-war culture; shifts in definitions of what constitutes the ideal intimate relationship and to more open 'talking about emotions' to close friends and family

Socio-demographic position: low socio-economic position, masculinity and mid-years

The impact of these processes has not been uniform across society; they pose challenges in particular to the group of men currently in mid-life, and these challenges are exacerbated when men occupy low socio-economic positions. These men will have grown up with the expectation that, when they reach the mid-life stage, they will have a 'job for life' in a traditional occupation, provide for their families, be 'strong and silent', the respected head of the household and taken care of by a wife. However, societal change means they are likely to experience challenges in meeting these expectations.

The move to a service-based economy and decline in traditional male occupations has created challenges for men of low socio-economic position in particular. This economic restructuring has led to higher unemployment for men, particularly in unskilled or semi-skilled occupations. Unemployment or financial troubles are generally more distressing for men because of their investments in work as a way of constructing their masculine identity, and problems with work means simultaneous failure in their family role as 'provider'. For working class men, the decline of traditional 'male' occupations has resulted in the loss of an important source of masculine identity and pride. Low educational attainment and cultural beliefs about appropriate jobs for men may mean they struggle to adapt to a changed labour market.

Men in mid-life have a narrowness of emotional and social connections; they are overwhelmingly dependent on a female partner as an 'emotional conduit'. However, in the current period, men are far more likely to experience relationship breakdown, not to have a single 'stable' marriage or female partner, or to be living alone, with little or no experience of how to cope emotionally on their own, or of seeking help to fall back on should they need it – at a time when they are under considerable economic pressure. When relationships break down, men lose a source of masculine respect and identity, and can feel a sense of shame and dishonour. In addition, where men come to live in different households, their contact with their children tends to be reduced. The loss of the father role is a further loss of masculine respect and identity, while separation from children increases some men's isolation. With the decline of traditional male work and unemployment, working class men have also lost an important source of companionable relationships with other men.

Men currently in their mid-years are caught between the traditional masculinity of their fathers and the more individualistic masculinity of their son. They are experiencing demands for increased 'equality' in relationships with wives/female partners, increased intimacy in the 'pure love' relationship, open expression of emotions, 'involved' fatherhood; and a more individualistic culture, in which the individual (rather than social structures) is 'responsible for shaping his/her own destiny' – and to blame if he/she fails. These cultural shifts challenge men's understanding of what it is to be a man. Men are caught between declining and emerging cultures, while their own socialisation as boys/men leaves them without the social and emotional skills to negotiate such changes.

Importantly, these challenges pertain not only to men of lower socio-economic position, but to men in mid-life across social classes. However, middle class men have more resources to adapt to the changing labour market and to find alternate ways of attaining masculinity in mid-life; it is not so much that the underlying characteristics of masculinity have changed for these more affluent groups, but that its trappings and expression are different and more diverse. For working class men, the avenues

and resources open to them to attain and demonstrate masculinity are considerably constrained. This contributes to the exaggerated, visible expressions of masculinity, such as fighting and drinking, associated with working class culture. For working class men, masculinity still strongly revolves around 'respectability', being a worker, provider and husband – while their disadvantage within the process of economic restructuring makes it more likely they will be unable to meet the demands of these linked roles in the mid-life stage, and to 'fail' as a man.

Individual context

Thus, an individual of this socio-demographic group – male, in mid-life, of low socio-economic status – will have increased likelihood of experiencing multiple risk factors for suicide – unemployment and financial difficulties, relationship breakdown, social disconnection, substance misuse, etc. The set of difficulties will be particular to the individual; problems in one area may impact on another (for example, unemployment may result in relationship strain; relationship breakdown may mean moving into poor housing or homelessness), and some men will experience multiple difficulties simultaneously, so there is no area of life to generate meaning and resilience, and suicide risk is increased.

Individual factors

But only a relatively small number of men within this group will go on to develop suicidal thoughts and fewer to take action to end their lives. Individual genetic, personality and psychological factors, including mental health problems, play a role. The way an individual perceives their circumstances matters, as well as the objective circumstances; and a person's behaviour influences their contexts (for example, poor problem-solving skills and responding to challenges in work or personal relationships with avoidance or aggression will make difficulties in these areas more likely).

Masculine identity and psychological factors for suicide

Suicide is ultimately the act of an individual, but to understand suicide at the psychological and individual level it is important to add in masculine identity. Social expectations and definitions of masculinity structure individual men's patterns of thoughts, beliefs, emotions, behaviour and identity. Social constructions of masculinity can contribute to the development and maintenance of other personality and psychological features associated with suicidality; and may mean an excess of these features among men.

For example, unemployed men display higher levels of social perfectionism and generate fewer effective solutions to social problems compared to men in work or training; these psychological factors are linked to suicidality. Having poor social problem solving and emotional skills is the factor most evidently linked to masculinity. But the personality trait of socially defined perfectionism, which is associated with greater sensitivity to feelings of defeat, humiliation and failure, can be understood in the context of working class masculine 'respectability', where standing in relation to kith, kin and community retains its importance. In addition, socially defined perfectionism may be linked to the fact that men's social roles are more inflexible than women's, with more pressure on men to conform and thus more negative psychological or social consequences for men who fail to attain conventional masculinity. There is evidence that men who occupy more traditional masculine identities, and are rigid in their beliefs about what is normative for men and women, are more at risk of unhealthy behaviours and suicide (Payne et al., 2008; Houle et al., 2008; Mahalik et al., 2007). Perceived burdensomeness (the belief that one is so incapable that one is a liability or hindrance to others) may be experienced particularly by men, because independence and autonomy is central to successful masculinity, and being in need of help from others constitutes failure.

Thus, when looking at individual personality traits and psychological factors, it is important not to

view these only as 'personal deficits' – failings of an individual – but also to understand the social context and constructions of gender which inform and maintain men's identities.

The states of shame and dishonour need to be included in psychological models of suicidal behaviour for men. At the centre of the 'cry of pain' model of suicidal behaviour is the experience of defeat/humiliation. This comes originally from social rank theory, in which an individual is prevented from achieving a goal – defeated/humiliated – by a more powerful individual. Humiliation is the experience of abasement, loss of pride, being shown as powerless, diminished, reduced to lowliness or submission. This may be particularly challenging to masculinity, which is inherently competitive, and requires recognition of one's masculine standing by others. The experience of humiliation may be more likely for men of lower socio-economic position, as this status means they suffer powerlessness, disrespect, stigma and difficulties achieving hegemonic masculinities. For some men, a life of shame, disrespect and dishonour is not worth living. Masculine dishonour and concerns about public loss of face/respect appears to play a role in men's suicides (Fincham et al., 2011; Scourfield, 2005). The relationship between masculine shame/dishonour and the experience of defeat/humiliation, which is at the centre of current models of suicidal behaviour, should be explored further.

Completed suicide

Factors which contribute to higher rates of completed suicide in men are: the normalisation of suicide as an option ("this is what men like me do in response to situations like this"); gendered cultural scripts that construct suicide as an act of 'mastery' and men's survival of a suicide act as 'failure'; gendered associations with, and access to, more lethal methods; tolerance of pain and thus greater capability of suicidal behaviour; risk-taking behaviour and alcohol misuse.

Conclusion

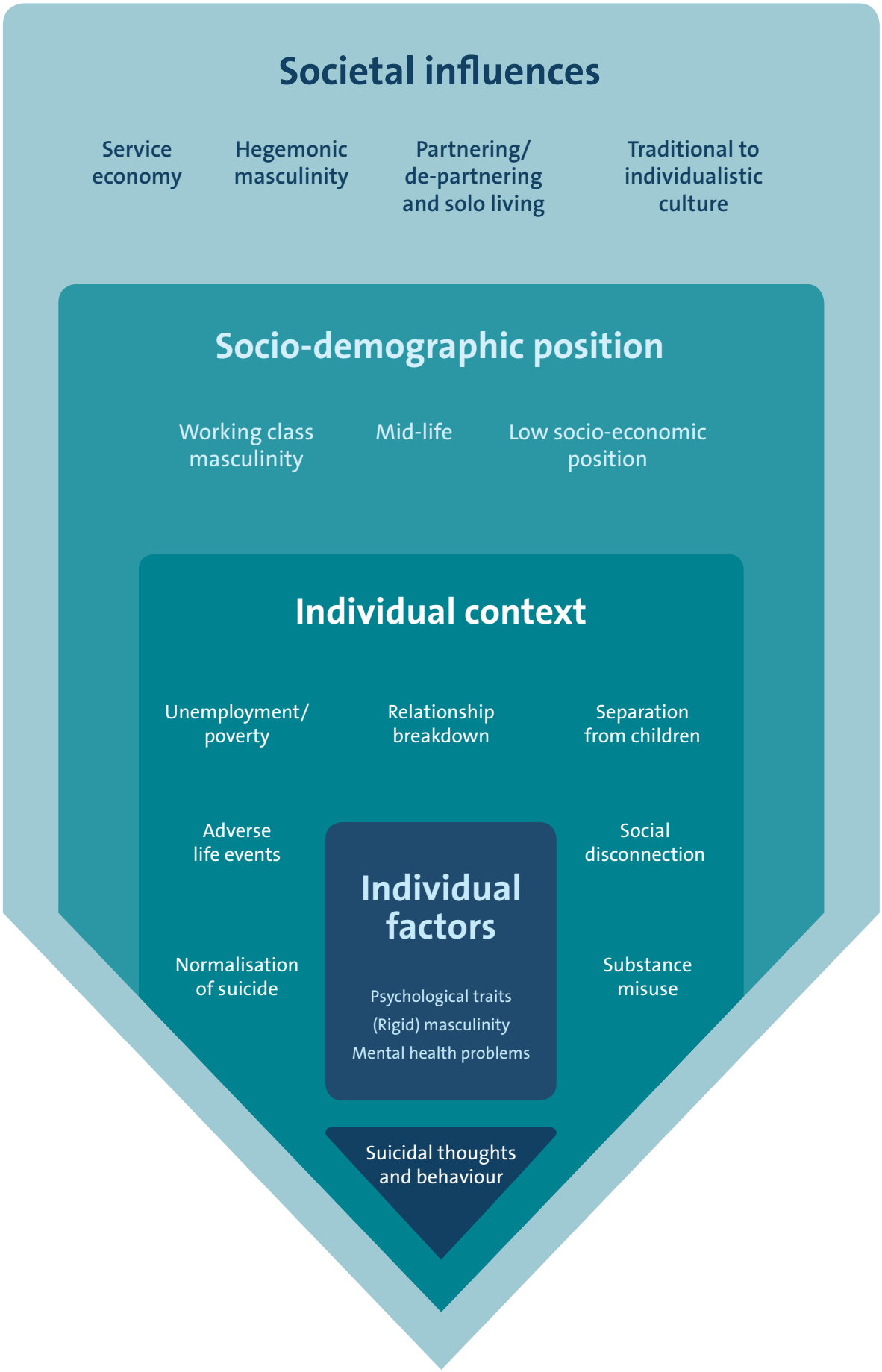
This report has responded to calls to move beyond the usual psychiatric, biomedical and epidemiological suicide research and explore evidence and theory from psychology, sociology, economic and gender studies, in order to explain why men of low socio-economic position in their mid-years are at excessive risk of suicide.

Suicide is an individual act, the tragic culmination of mental health problems, feelings of defeat, entrapment, that one is worthless, unloved and does not matter. However, these feelings are produced within a particular social, economic and cultural context: for disadvantaged men in mid-life, toxic definitions of masculinity, failure to attain the ideals of hegemonic masculinity, cultural shifts in ideas of 'how to be a man' and in personal relationships, relationship breakdown, social disconnection, exclusion from a changing labour market and the negative consequences of being at the bottom of the socio-economic ladder.

This report has sought to look behind (and beyond) the individual risk factors for suicide, well-established in the quantitative literature – low socio-economic position, relationship breakdown, isolation, gender – to provide insight into the interaction between these factors, and why and how they matter to men in men in mid-life in this historical period.

The next section will look at policy and practice, which can also be considered part of this ecological model for suicide risk. The social and economic policy and suicide strategies of national government will influence the micro- and macro-level context, and provision of support services and initiatives locally will play a role at micro-level.

Figure 1 **Suicide in men of low socio-economic position in mid-life**



Implications for policy and practice

This section makes recommendations about how to reduce death by suicide in men of low socio-economic position in their mid-years, based on the findings of this report. The section begins by highlighting three general concerns before moving into Samaritans' recommendations for policy and practice.

It should be noted that, as throughout this report, the role of mental health problems in suicide is taken as given, and thus the need for policy and practice to promote mental wellbeing, identify and treat mental health problems, and address the high risk of suicide in people with mental health problems, is also taken as given.

Three general concerns

Suicide research needs to investigate what interventions work for whom under what circumstances.

There is dearth of evidence on effective interventions to reduce suicide in disadvantaged men in their mid-years.[8] In general, studies of interventions to reduce suicide fail to report on the demographic details of their participants and tend to combine outcomes for participants from different gender, ethnic or socio-economic groups; and there are few studies evaluating interventions developed explicitly for 'high risk' demographic groups (Leitner et al., 2008, p. 23). This lack of attention to context and demographics contributes to the mixed outcomes reported for different interventions in the research: "suicidal behaviour is not a unitary phenomenon and the outcome of intervention is likely to be highly context specific" (Leitner et al., 2008, p. 26). Even with regard to young men – which have been the focus of suicide prevention strategies for a decade – evidence as to which interventions reduce suicide is limited (Pitman et al., 2012).

This report supports the call for more attention to social context in suicide research; to move from describing suicide and its risk factors to understanding suicidality, as much as possible from the perspective of those affected; and for understanding what works for whom under what circumstances (Hjelmeland and Knizek, 2011; O'Connor et al., 2011; Fincham et al., 2011). In addition, more needs to be done to join up suicide research, policy and practice, so that research agendas are more informed by the needs of practitioners and policy-makers, and research evidence is central to the development and implementation of policy and practice. As remarked by O'Connor et al. (2011, p. 630), in their review of the state of suicidology based on input from a range of experts, the overarching challenge facing suicidology is translating knowledge into action to save lives. In the UK and Republic of Ireland, more should be done to share best practice between countries.

Attention must be given to the needs of boys, teenagers and young men to prevent vulnerability in later years.

Many of the vulnerabilities present in disadvantaged men in their mid-years are established in childhood and adolescence, particularly through the negative impact of low socio-economic position, dysfunctional families, the effects of partnering and de-partnering and absent fathers, problems with education, and socialisation into gender roles. Policies need to pay special attention to the gendered needs of boys (Wilkins & Kemple, 2010). There is room for social and educational programmes which encourage critical reflection on gender role socialisation (see Featherstone et al., 2007). Opportunities should be

taken to develop these programmes for young people in schools, colleges and youth clubs. In addition, effective interventions are needed to address the difficulties young men (and women) face to enter the labour market in the context of the economic recession. Unemployment experienced in the teenage years creates vulnerabilities which impact negatively on wellbeing and suicide risk throughout the life course.

Progressive social and economic policies are required to tackle the root causes of suicide in men (and women) of low socio-economic position.

Many of suicide's immediate and long term causes lie in socio-economic factors; governments need to address the root causes of the vulnerabilities of men (and women) from lower socio-economic groups by adopting progressive (gender sensitive) social and economic policies. Challenges to be tackled include socio-economic deprivation and inequalities (including the polarisation of working and workless households), health inequalities, unemployment, social exclusion, and the precariousness of welfare and benefits safety nets.

There is clear evidence that the welfare and labour market policies adopted by governments can offset the adverse effects of recession and increased unemployment on suicide. For example, one study showed that, for every US$10 higher investment in active labour market programmes, there was a 0.038% lower effect of a 1% rise in unemployment on suicide rates in people aged under 65 years. When this spending was greater than US$190 per head per year, a 3% rise in unemployment was estimated to have no significant adverse effect on suicide rates (Stuckler et al., 2009).

Recommendations

Samaritans calls on national government, statutory services (such as health, welfare, employment and social services), local authorities and the third sector to recognise the heightened risk of suicide in disadvantaged men in mid-life and take action to reduce suicide in this group.

1
Ensure that suicide prevention strategies include explicit aims to reduce socio-economic inequalities and gender inequalities in suicide.

There are systematic socio-economic inequalities in suicide risk: the suicide risk of those in the lowest social class living in the most deprived areas is approximately 10 times higher than the risk of suicide among those in the highest social class in the most affluent areas, and there is a gradient in risk, with progressive increases in risk for each lower social class. But suicide has not been addressed as a health inequality – an avoidable difference in health and length of life that results from being poorer and disadvantaged. Nearly all national suicide prevention strategies (with the exception of New Zealand) have focused on the overall reduction of suicide, without specific aims or targets to reduce the unequal distribution of risk by socio-economic position (Platt, 2011).[9] That men are three times more at risk of suicide than women is an inequality in suicide risk based on gender. National suicide prevention strategies include men as a high risk group, but they have not applied the various analyses, approaches and tools that have been developed to address gender inequalities in other contexts. National and local suicide prevention strategies and action plans should explicitly aim to reduce the socio-economic and gender inequalities in suicide risk. This is not an easy task and there are many questions about the best ways to achieve this. Nonetheless, it must be attempted.

2
Inform suicide prevention measures with an understanding of men's beliefs, concerns and contexts – in particular their views of what it is to 'be a man'.

Much of the current discourse around men and health is unhelpful in 'upbraiding' men for being 'resistant to help-seeking' or 'not talking about their feelings', without sufficiently recognising the ways in which constructions of masculinity, and social and cultural context, constrain men's

behaviour. Practice needs to move from 'blaming men for not being like women', to removing the barriers to men's engagement with projects and services, and designing/adapting interventions to be attractive to them and effective for them.

Gender identity is fundamental to an individual's sense of self and traditional masculinity continues strongly to inform the identities of this group of men. Interventions need to engage and work with 'who men are' and what is important to them at this time. For example:

- reframe help-seeking from 'dependence' to a way of maintaining independence, taking action/control and solving problems, in order to be compatible with masculinity (Oliffe et al., 2012; Emslie et al., 2006)
- go to where men are comfortable (for example, pubs, snooker halls and sporting venues) and work with and through organisations engaged with men (Johal et al., 2012)
- use non-threatening 'hooks' that interest and attract men initially (Johal et al., 2012)
- change the 'face' of services – many spaces where services are delivered are 'feminine' and frontline staff are more frequently women, which can create the perception that services are for women (Johal et al., 2012; Wilkins & Kemple, 2010)
- encourage men (who have experienced similar difficulties) to be visible as volunteers and advocates (Johal et al., 2012)
- establish individual relationships of trust which help men into projects (Johal et al., 2012)
- allow men to be 'spontaneous' in seeking help, as planning to talk or seek help is seen as emasculating
- ensure the availability of anonymous, confidential services which are more likely to attract men to seek help at low cost/risk to their 'manliness'
- make best use of new communications technologies: these will be familiar to people now in mid-life; and, in older age bands, more men than women use the internet (Office for National Statistics, 2012).

However, aspects of traditional masculinity are damaging for both men and women. It is important not simply to reinforce toxic masculinities, or undermine or stigmatise those men who do not conform. Interventions should also enable alternate ways of 'being a man'. Campaigns or services should work with the sense of ambivalence felt by men in their mid-years, who experience the push of new discourses of masculinity, while also feeling the pull of the old.

3
Enable inter-agency working to address the multiple difficulties experienced by men in mid-life, through clear allocation of responsibility and accountability for suicide prevention at local level.

Men of low socio-economic position in mid-life face a complex bundle of interacting circumstances: financial, employment or housing difficulties, social disconnection, relationship breakdown, substance misuse and mental health problems. Social care, employment, housing providers, health services, police and offender services and the third sector need to be joined up in order to provide "'whole-life' solutions to 'whole-life' problems" (Wilkins & Kemple, 2011, p. 13). However, while calls for inter-agency working are often made, they are seldom achieved at the frontline. There must be an individual within local statutory structures with clearly designated responsibility and accountability to lead and coordinate local suicide prevention plans and connect the operations of multiple agencies at local level (for example, as in the Scottish suicide prevention 'Choose Life' model).

4
Support GPs to identify and respond to distress in men, recognising that GPs are the most likely formal source of help to be consulted by this age-group.

For adults, GPs remain the first port of call for formal help, with consultation with a GP when worried, stressed or down far more common than use of psychiatry, psychology, counselling or therapy. Men may well present initially with physical or substance misuse problems, but do also disclose emotional distress to GPs, particularly in

times of crisis, and where the GP has been known to them or their family over time; the way GPs respond can make a very great difference to their lives. Studies have shown GP education to increase the number of diagnosed and treated depressed patients, with accompanying reductions in suicide (Mann, 2005), although the overall evidence on this issue is mixed (Leitner et al., 2008). GPs must be equipped to identify and enable disclosure of distress in men; but it is also important that there are appropriate services to which GPs can then refer men, and that there is ongoing management of care across health and other services (Leitner et al., 2008).

5
Provide therapies which address the specific psychological factors associated with suicide – particularly, for men, social and emotional skills, managing stress and the expectations of others.

Generic 'talking' therapy may not be effective for this group of men, because they do not believe that 'talking about feelings' helps and may struggle to do so; and also because the specific psychological factors generating their suicidality are not being addressed. The NICE clinical guidelines for self-harm should be applied, also for those who are suicidal but have not yet self-harmed or attempted suicide: "psychological intervention should be tailored to individual need and should include cognitive-behavioural, psychodynamic or problem-solving elements" (2011, p.9). In particular, men should be supported to develop social problem-solving skills, given the negative impact of poor social skills on both personal relationships and work contexts, and the role of social disconnection in men's suicidality. Because of men's perceptions of the inefficacy of 'talking', it may be important to frame such interventions as 'training' rather than 'therapy', and include them within wider skills development programmes (see below).

Psychological interventions should recognise that some 'psychological factors' and 'personality traits' linked to suicidality in men are not solely 'personal deficits', but relate to socially constructed masculinity and the social pressures on men to behave in certain ways. Practitioners can work with, as well as reframe, perceptions of 'what is manly' through the therapeutic process (O'Brien et al., 2005).

In working with the individual, proper attention needs to be given to their circumstances, which may be generating their distress or constraining their ability to 'move forward'. Ecological approaches, which have migrated from child services to use in a variety of health and social problems, could be used to map areas of life (work, family, friends, recreation, etc), locating sources of challenge to be addressed, as well as sources of support and resilience to build on. The principle of this approach is already contained in the NICE guidelines for self-harm.

In general, as the research into the specific psychological factors associated with suicidality (in men) advances, there must be investment in developing and providing therapeutic interventions which address these factors.

Despite the fact that poorer people are more likely to experience serious mental ill-health and lower subjective wellbeing, they remain relatively much more likely to be prescribed medication in the face of emotional difficulties. While medication can play an important role in addressing mental health problems, such as depression, there should not be a substitution of medication for other forms of support among those in lower socio-economic positions.

6
Develop innovative approaches to working with men that build on the ways men do 'get through' in everyday life.

The focus tends to be on men's methods of 'coping' as dysfunctional, for example, by excessive consumption of alcohol, ingestion of illicit drugs or avoidance techniques. However, men also do 'get through' by using other often 'non-verbal' ways of coping. These include 'being or doing alongside' male friends, exercise, listening to music and other task-orientated activities. Approaches should

support and encourage everyday ways of coping that are culturally familiar to, and used by, men themselves. Given men's greater use of bodily ways of 'coping', it is possible that encouraging men to get involved in team sports or other 'non-talk', yet social, activities may be helpful. In addition, it should be possible to recognise the importance men give to being self-reliant by providing 'self-management' tools, tailored for men.

7
Join up alcohol and drugs strategies and services with suicide prevention, recognising the links between substance misuse, masculinity, deprivation and suicide.

Substance misuse and suicide prevention strategies, as well as services and interventions, must join up, given the association between suicide and substance misuse, and men's propensity to use alcohol and drugs in response to distress. While the alcohol strategies of Wales, Ireland and Northern Ireland do reference suicide and self-harm, these remain absent from the Scottish strategy (The Scottish Government, 2009) and from the Westminster government's alcohol strategy (Home Office, 2012). On the ground, substance misuse services must respond to the suicide risk associated with alcohol and drug misuse, particularly for men of low socio-economic status, and especially in the context of relationship breakdown and loneliness (Conner & Ilgen, 2011). Both suicide prevention and alcohol and drugs policy and practice need to address the association between excessive drinking, low socio-economic position, culture and masculinity.

8
Recognise the profound role of social disconnection in the suicide risk of men in mid-life, and support men to build social relationships.

A burgeoning evidence-base shows that the presence and strength of social connections – such as marriage or partner, family, ties to friends and neighbours, workplace ties, civic engagement – are one of the most robust predictors of life satisfaction and subjective wellbeing: social relationships make us happy and healthy. Conversely, the lack of social relationships constitutes a major risk factor for health and mortality, rivalling the effects of risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical inactivity (Helliwell & Putnam, 2004, p. 1436; Holt-Lundstad et al., 2010, p. 2). Real or perceived lack of supportive relationships is a well-established risk factor for suicide (Centers for Disease Control and Prevention, 2008); suicidal individuals consistently report lower levels of social support compared to those who are not suicidal (e.g., O'Connor, 2003).

Men's loneliness, the actual or perceived lack of people who care and to whom they matter, can be profound. The likelihood of social disconnection among men in mid-life – particularly if unemployed and without a partner – and the fundamental role this plays in their high risk of suicide, must be recognised. The American government's public health arm defines as its strategic direction to prevent suicidal behaviour "building and strengthening connectedness or social bonds within and among persons, families, and communities" (Centers for Disease Control and Prevention, 2008). While suicide prevention strategies in the UK and Ireland acknowledge social isolation and disconnection as a risk factor, they have not developed the promotion of social connectedness as a suicide reduction measure. Building men's 'social connectedness' should be integral to suicide prevention for men in mid-life.

Services may provide 'surrogate' social support for men for a period: there is evidence that ongoing maintenance of contact with a suicidal person, non-directive telephone-based support, befriending and setting up informal networks of support reduce suicidal feelings and behaviour (Leitner, et al., 2008). Services should also spend their contact time with men building social skills and encouraging them to develop sustainable sources of support in their own lives and communities. Interventions which build on men's 'non-talk' based intimacy with other men may be helpful. Community-level initiatives directed at men and encouraging positive activities, socialisation and interaction, may be

important, particularly in deprived socio-economic contexts, where there may be a lack of hope, vision of a future and opportunity.

Services should recognise the heightened risk of suicide in men in the context of relationship breakdown. There should be promotion and greater free provision of services such as relationship counselling and mediation, to build relationships skills and mitigate the most damaging aspects of relationship breakdown. This can be especially helpful when there are disputes over children. However, men's need for control and dominance in intimate relationships should be challenged.

Other people, particularly partners and family, but also friends, can play a key role in recognising distress in men and encouraging them to seek help, and can become part of the care and support for them (see also NICE guidelines, 2011). Interventions which facilitate and support the role of these third parties should be considered (Wilkins & Kemple, 2011).

9
Assist men excluded from the labour market to (re)enter employment.

Given the association between unemployment and suicide and the importance to men of the breadwinner role, it is vital that men (especially those living in disadvantaged economic circumstances) are helped to become more engaged in the labour market. Interventions will need to include re-training, but will also have to address men's perceptions that some kinds of work are 'not for men'. Social problem-solving, the management of the expectations of others and alternate (non-risky) responses to stress should be incorporated into training activities targeted at men who are unemployed. Randomised controlled trials of interventions for unemployed people, including cognitive behaviour therapy, workshops and problem-solving, have demonstrated improvements in mental health as well as re-employment rates (Vuori & Silvonen, 2005). Of course, employment opportunities have to be available within the economy.

Endnotes

1. For the Republic of Ireland, figures from the Central Statistics Office Ireland (CSO), for 2010, show 220 men aged 35-64 died by suicide. In terms of rates, 26.7 men per 100,000 aged 35-44 died by suicide, 27.2 per 100,000 aged 45-54, and 23.8 for 55-64; while 25 per 100,000 male 15-24 year olds took their own lives and 20.1 25-34 year olds. The average rate for adult women was 5.5. The UK and Republic of Ireland figures are not comparable since the ONS (UK) include both Deaths by Intentional Self Harm (ICD10: X60-84) and Deaths by Undetermined Intent (ICD-10: Y10-34) in the number of suicides, whereas the CSO (Republic of Ireland) only include Deaths by Intentional Self Harm (ICD10: X60-84). In addition, the ONS provide rates that are age standardised to the European population, whereas the CSO does not; thus the Republic of Ireland rates provided here are crude rates.
2. Thank you to Professor Gill Jones, Keele University; Professor Jonathan Scourfield, University of Cardiff; Dr Amy Chandler, The University of Edinburgh and Dr Debbi Stanistreet, University of Liverpool, for the discussion day on 29 November 2010, which informed the scope of this report.
3. However, in recent years there appears to be a narrowing of the gap in self-harm between men and women in some parts of the world (Payne et al., 2008).
4. For example, see the research priorities identified by the Department of Health, Policy Research Programme, 'Research initiative to support the implementation of the national suicide prevention strategy', 2012. The research priorities include: to improve the understanding of self-harm, suicide and effective interventions for people from black, Asian and minority ethnic groups and asylum seekers; lesbian, gay, bisexual and transgender people, and children and young people. Of relevance to the argument in this report, the initiative does not prioritise research into suicide in men, or people in mid-life, or the relationship between suicide and lower socio-economic position.
5. Suicide statistics and evidence, including that reviewed in the report, does not generally include or disaggregate sexual identity and ethnicity as well as class and age; some of those included in the numbers of suicides which constitute the high risk of suicide in men in mid-life will be from BME and LGBT groups. The wider evidence suggests in the UK, risk of suicide is lower in BME groups than in the white population (although this does vary by ethnic group, age group, gender and location), and higher among LGBT people than heterosexual people (King et al., 2008).
6. References are provided only where content is derived from sources other than the five articles commissioned for this report.
7. For a full account of the IMV model see O'Connor, 2011. Although the IMV model is most explicit in respect of psychological factors, it also takes account of biological and social factors.
8. This assertion is based on the reviews of evidence used to inform national suicide prevention strategies in the UK and Republic of Ireland (Arensman, 2010; Guo & Harstall, 2004; Leitner et al., 2008; Mann et al. 2005; Price et al., 2010); and NICE clinical guidelines for self-harm (NICE, 2011).
9. The Equality Act 2010 (England) creates a public sector duty regarding socio-economic inequalities, requiring that authorities: "when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage" (1(1)). However, the 'Assessment of impact on equalities' for England's national suicide prevention strategy (September 2012), focuses on the nine protected characteristics, and does not reference the evidence regarding socio-economic inequalities in suicide risk. Socio-economic factors are covered by the sentence: "people who are especially vulnerable due to social and economic circumstances" are included under area for action 2 in the strategy (Department of Health, 2012a, p. 8), which is to 'tailor approaches to improve mental health in specific groups' (Department of Health, 2012b, p. 21).

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Gender, relationship breakdown and suicide risk: a systematic review of research in western countries

by Rhiannon Evans, Jonathan Scourfield and Graham Moore

Abstract

This paper presents a systematic review of the evidence on gender differentials in suicide risk after breakdown in intimate relationships (including divorce and separation). Twenty-nine published papers were identified, which included analysis of individual-level data and ecological studies. Of these, 17 found suicide risk to be higher in men, six found risk to be higher in women and six had no consistent findings on gender difference. The review also considered the evidence of differences between men in suicide risk when relationships break down. Three studies found a larger gender differential for younger men and a further three found a larger gender differential for men in mid-life. However, there were more studies indicating a higher suicide risk for men in mid-life post-separation or divorce than for younger men. The paper presents a discussion of theoretical insights from social science that might help to explain the gender differential, including marriage as a more positive experience for men than for women, men's loss of honour, the changing nature of intimacy, the increasing importance to men of the care of children, control in relationships and men's social networks. The paper concludes with possible implications for policy and practice.

Introduction

The association of marital status with suicide has been noted since the pioneering work of Durkheim (2002 [1897]). Studies have consistently noted greater prevalence of suicidality in divorced individuals and higher suicide rates in areas where the divorce rate is highest (Stack, 2000a), although the evidence can be inconsistent at a population level (Gunnell et al., 2003). While it has been argued that in popular culture, suicide following relationship problems is feminised, that is, culturally associated with women (Canetto, 1992; 1997). However, the findings of some studies that men are in fact more at risk of suicide following relationship breakdown than women suggest the need for a systematic review of the evidence in relation to gender. While the available data are likely to favour using formal marital status (married, separated, divorced) as the indicator of relationship status in most studies, a broader category of the breakdown of intimate relationships is in fact relevant. A relationship crisis might trigger a suicidal act even in a formally intact couple and also the social significance of marriage has changed considerably in recent decades, with many couples co-habiting outside formal marriage or civil partnership. An exclusive focus on 'marriage' also restricts the focus to heterosexual couples, which is not the intention of this review. In what follows, the term 'relationship

breakdown' is used most often, in reference to when intimate partner relationships experience serious problems or termination.

The review is based on two research questions:

- What is the differential effect of relationship breakdown (including divorce and separation) on suicide risk in men and women?
- If there is a differential effect between men and women, how does this effect vary according to age and socio-economic status?

Method

The electronic databases ASSIA, Medline, Medline in Process and PsycINFO were searched for literature between the years of 1970 and 2012. The year 1970 was selected in order to capture the rise of second wave feminism, combined with legislative changes to divorce laws, such as the Divorce Reform Act (1971) in the UK. The search returned English language articles that contained the selected search terms. These search terms comprised relevant suicide risk measures (suicide; suicide behaviour; fatal behaviour; suicide attempt; parasuicide; suicidal ideation; suicide risk) and relevant causal factors (divorce; separation; relationship breakdown; marital problems; marital status). The titles and/or abstracts of 1066 articles were reviewed (including 18 articles identified through reference lists). The papers were screened and appraised with regards to the following selection criteria:

- The study sample comprises the general population.
- The study is conducted in 'western' countries, i.e. those with roots in European culture.
- The study's causal factor focuses on relationship breakdown (divorce, separation, relationship problems) in relation to suicidal behaviour, and does not categorise individuals according to the binary of married/non-married or collapse different types of non-marriage (e.g. widowhood, separated/divorced, and never married) into one category.
- The study analyses the relationship between the causal factor and outcome measure in relation to gender.
- The statistical test and analysis are clearly and reliably stated.

The full exclusion/inclusion criteria for the study are presented in Appendix A. The review encompassed both individual-level and population-level studies. Given that intimate relationships are a social phenomenon with potentially different meanings in different cultural contexts, it was important to ensure the review was specific to countries with some broad cultural and economic similarities. The decision was therefore taken to include only studies of Organisation for Economic Co-operation and Development (OECD) countries with a broadly European cultural heritage.

Screening identified a total of 52 articles whose abstracts suggested potential relevance. Of these articles, 23 were excluded once full text was accessed, on the grounds of presenting insufficient inferential statistics or details of the statistical test used, or for not answering our research questions (e.g. papers which examined mediating factors associated with suicide following divorce among men and women, but did not compare rates between men and women). Subsequently, 29 papers met the inclusion criteria of the systematic review and have been included in the study (see Appendices B and C). As noted above, it was important for searching to encompass any breakdown in relationship, regardless of the legal status of the relationship. However, all the papers selected for the review did in fact use the more formal categories of divorce and/or separation.

Results

The majority of the studies included in the review (16) are European. Apart from one study of 15 European countries, the rest of the European papers cover 10 different countries in total. Seven papers are based on data from North America and five on data from Australasia. One study is international, with data from 21 developed countries. Only two of the studies are specific to the UK. Outcomes include suicidal ideation, suicide in individuals and area-level suicide rates. Nineteen studies used individual-level data and 10 compared area-level suicide rates.

Relationship breakdown and gender

Both divorced and separated males and females have been found to be at an elevated risk of suicide compared to their married counterparts (Lester, 1992; Lester, 1995; Burgoa et al., 1998; Kposowa, 2003). However, while it is rare to see formal statistical comparisons of sex differences in the strength of associations of divorce with suicide (i.e. via the use of sex*marital status interaction terms), the majority of studies reviewed suggest that men are at a greater risk of suicide than women in the aftermath of relationship breakdown.

While most studies in this area present separate analysis by gender, comparing suicide risk among divorcees and married persons, other studies include only divorcees, comparing suicide rates for men versus women among this group. This latter form of comparison should be treated with caution, given that higher levels of suicide or suicidal ideation among divorced men may reflect gender differences which are not related to divorce (suicide is also typically more prevalent in married men). Nevertheless, it is worth noting that divorced males have been shown to have higher levels of suicidal ideation than divorced females (Zeiss et al., 1981), with separated men being twice as likely as separated women to have made plans about committing suicide (Kõlves et al., 2010). Data presented by Walsh et al. (2009) show that the departure of an intimate partner is cited in coroners' records as a contributing factor to a greater number of male than female suicides. Elsewhere, the risk of suicide amongst divorced males compared to married males has been shown to be 3.79, while the risk for divorced females compared to married females has been shown to be lower at 1.47 (Petrovic et al., 2009). Burgoa et al. (1998) also found that divorced or separated males were almost three times more at risk than married males, while divorced or separated females were only 1.5 times as likely to commit suicide as were married females. Andrés (2005) found an approximately four times greater increase in suicide amongst men than women when the divorce rate increased, while Barstad (2008) found a larger increase in suicide rates for men than women when separation rates were higher, although both were significant. Furthermore, Rossow (1993) has noted a significant relationship between suicide and divorce, but not in females. In a study which compared suicide rates for divorced and married males and females, Kposowa (2000) found that the risk for suicide amongst divorced men was almost three times that of married men; there was no significant suicide risk for divorced women. Gunnell et al. (2003) found a positive relationship between the divorce rate and suicide for males aged 25-34 but a negative relationship for females for a comparable age range.

Studies that have considered cultural context, such as the role of religion, have also indicated a slightly elevated risk amongst men. Fernquist (2003) found a significant association between divorce rates and suicide rates in highly religious countries, with this association being slightly greater for men than for women. There was a significant association between divorce and suicide in women only when divorce was an infrequent occurrence, while there was a significant relationship for men irrespective of whether the country had higher or lower divorce rates.

The evidence base is not unequivocal, however. Some studies suggest that, while divorce and separation might elevate the risk of suicide, there is no clear gender differential (Trovato, 1991; Heikkinen & Lonnqvist, 1995; Masocco et al., 2008; Cupina, 2009; Denney et al., 2009; Masocco et al., 2010). Moreover, Fekete et al. (2005) found that divorced individuals who complete suicide were actually more likely to be female than male. Agerbo (2005) found that the incidence rate for separated men and divorced men compared to married men was 1.93 and 1.75 respectively, while the incidence rate for separated women was 1.97 and for divorced women, 1.68. Additionally, Rodriguez-Pulido et al. (1992) found that divorced women were 8.5 times more likely to complete suicide than married women, while divorced men were eight times more likely to complete suicide than married men. Furthermore, data provided by Agerbo et al. (2011) indicate that a 1% increase in divorce is associated with a 0.52% increase in suicide rates in men, whereas the same percentage increase in divorce is

associated with a 1.12% increase in suicide in women.

To summarise the findings of the 29 studies included in this systematic review, 17 suggested that divorced or separated males were at a higher risk of suicide than their female counterparts, six found that divorced or separated females were at an elevated risk, and six found no consistent evidence of a gender differential in suicide risk. Table 1 (below) presents a summary of research findings.

Relationship breakdown, gender and age

While Kreitman (1998) found that marital status was a stronger correlate of suicide than age for most age groups, the interaction of age and marital status suggests that the suicide risk associated with divorce or separation is not borne equally across all age groups, and the gender differential is also different across the life course. Six of the reviewed studies compared suicide risk across the lifespan in both males and females. There are difficulties encountered in drawing conclusions because of the diverse and over-lapping age bands used. However, it can be noted that three studies found the difference between males and females to be more prominent in the relatively younger age bands of 20–34 (Corcoran & Nagar, 2010) and 25–44 (Masocco et al., 2008; Masocco et al., 2010), while three studies found that the difference was highest in mid-life, namely the age bands 30–54 (Cantor & Slater, 1995), 40–64 (Burnley, 1995) and 35–54 (Cutright & Fernquist, 2005) (see Table 2 below).

At this point we consider risk by age for men specifically, as most of the reviewed studies found men to be most at risk of suicide when intimate relationships end. The interaction between relationship breakdown and age shows that suicide risk for men varies across the life course. Of the six studies that compared suicide risk in separated or divorced males across the lifespan, four of the studies found that middle-aged men, ranging from 30–64, were at most risk of suicide (Cantor & Slater, 1995; Burnley, 1995; Masocco et al., 2008; Masocco et al., 2010). Only one study found that younger men, aged 20–34 were at the highest risk (Corcoran & Nagar (2010). One study (Cutright & Fernquist, 2005) found that no particular age groups were at an elevated risk, although among those aged 55+ there was a weaker association between divorce and suicide. Cantor and Slater (1995) found that separated men aged 30–54 were over seven times more at risk than their married counterparts, while Masocco et al. (2008) and Masocco et al. (2010) found that the odds of divorced or separated males aged 45–64 completing suicide compared to married men were OR=1.88 for divorced men and OR=1.77 for separated men. Meanwhile Burnley (1995) found the relationship between suicide and divorce in men to be slightly stronger in the age group 40–64. However, Corcoran & Nagar (2010) found that, compared to married males, suicide risk was higher among divorced males aged 20–34 (IRR=2.14) than divorced males aged 25–54 (IRR=0.91). (Table 3, below).

Relationship breakdown, gender and socio-economic status

None of the reviewed studies included sub-group analysis of gender differences in the association of relationship breakdown with suicide risk by socio-economic status. The closest to this kind of analysis was Kõlves et al.'s (2010) finding that suicide risk after separation was associated with lower educational qualifications and with property/financial problems for men, but not for women. This is not a finding about socio-economic status as such. Educational qualifications are likely to be associated with social class, though they are not a proxy measure for socio-economic status. Property and financial issues could, however, cause stress for men from all kinds of class background.

Type of relationship breakdown

While most studies group divorce and separation together, there has been a recent move to differentiate the terms and examine them as different phenomena (Ide et al., 2010). This may be an important step, for separation and divorce have been shown to have a differential impact on suicide rates, and of the three included studies that considered this differential impact, all three found

Table 1 **Summary of findings on gender differentials for suicide risk in the context of relationship breakdown**

	Males at elevated risk	Females at elevated risk	No consistent difference
Individual-level studies	Zeiss et al. (1981)	Rodriguez-Puildo et al. (1992)	Trovato (1991)
	Rossow (1993)	Fekete et al. (2005)	Heikkinen and Lonnqvist (1995)
	Cantor and Slater (1995)	Masocco et al. (2008)	Agerbo (2005)
	Burgoa et al. (1998)	Masocco et al. (2010)	Cupina (2009)
	Kposowa (2000)	Corcoran and Nagar (2010)	
	Cutright and Fernquist (2005)		
	Denney et al. (2009)		
	Petrovic et al. (2009)		
	Walsh et al. (2009)		
	Kõlves et al. (2010)		
	Kovess-Masfety et al. (2011)		
Ecological/ cluster-level studies	Burnley (1995)	Agerbo et al. (2011)	Lester (1992)
	Gunnell et al. (2003)		Lester (1995)
	Andrés (2005)		
	Barstad (2008)		
	Andrés and Halicioglu (2010)		
	Fernquist (2003)		

Table 2 **Gender differentials by age for suicide risk when relationships end**

Differential effect larger in younger age group	Differential effect larger in mid-life age group
Corcoran and Nagar, 2010 (Age 20–34)	Cantor and Slater, 1995 (Age 30–54)
Masocco et al., 2008 (Age 25–44)	Burnley, 1995 (Age 40–64)
Masocco et al., 2010 (Age 25–44)	Cutright and Fernquist, 2004 (Age 35–54)

Table 3 **Suicide risk for separated or divorced men by age**

Young age more of a risk factor	Mid-life more a risk factor	No difference
Corcoran and Nagar, 2010 (Age 20–34)	Cantor and Slater, 1995 (Age 30–54)	Cutright & Fernquist (2005)
	Burnley, 1995(Age 40–64)	
	Masocco et al., 2008 (Age 45–64)	
	Masocco et al., 2010 (Age 45–64)	

Table 4 **Comparison of suicide risk for separation and divorce in reviewed papers**

Separation more of a risk factor	Divorce more of a risk factor	No difference
Cantor and Slater, 1995		
Agerbo, 2005		
Barstad, 2008		

that separation posed more of a suicide risk (Cantor & Slater, 1995) Agerbo, 2005; Barstad, 2008). Ide et al. (2010) argue that there is currently insufficient understanding of the structural/systemic, social and psychological factors that may increase the risk of suicidal behaviours in the context of separation (Table 4 on see page 5).

Discussion

In discussing the implications of the review findings, we refer both to insights and explanations from the reviewed papers and to a wider body of social science literature on masculinity and men's relationships. The explanatory theories mentioned in the reviewed papers to shed light on their findings were speculative rather than empirically tested. Hence we have gone beyond the reviewed papers to draw on a wider field of theory and evidence. The evidence in this review comes from a number of different countries, but there is little firm basis for international comparison, so the issues will be discussed on the basis that associations of suicidality with marital status and with gender have some resonance across the western world, regardless of national context.

Why the association between relationship status and suicide?

Explanations of the relationship between marital status and suicide have been theoretically underpinned by Durkheim's (2002[1897]) concept of social integration, and more specifically domestic integration. This thesis suggests that marriage can diminish the prevalence of egoistic suicide, 1 as an individual's ego is subordinated by their spouse (Stack, 2000a). Consequently, marriage may offer a source of regulation to the individual, while also providing a sense of meaning. More recent work, building on Durkheim, suggests that marriage is a significant protective factor as it provides a healthier lifestyle for individuals through the reduced exposure to stress and increased access to social support networks, which can prevent the manifestation of anomie[2] while enhancing one's level of well-being (Gove, 1972; Trovato, 1991; Kposowa, 2000).

Conversely, divorce can increase the risk of suicide as the individual is detached from his/her domestic relationship, and comes to recognise no rules or action beyond their private interests (Durkheim, [1897] 2002; Stack, 2000a). Moreover, the cultural context in which divorce occurs can increase the prevalence of suicide. As Kposowa (2000) suggests, within western societies there is a strong cultural emphasis on achieving a strong and happy marriage, and consequently those who divorce may 'experience a deep sense of disorientation, shame, guilt, and a generalized feeling of emotional hurt' (Stack, 2000a, p. 167). This sense of shame may be particularly important, with Kõlves et al.'s (2010) study finding that separated males and females who experienced suicidal ideation exhibit much higher levels of internalised shame than separated individuals who are not suicidal. Shame might also explain the observations of Fernquist (2003) that associations of divorce with suicide are higher in highly religious countries, or countries with lower overall rates of divorce (i.e. where divorce is likely to meet social disapproval or transgress cultural norms).

However, the plausibility of these theoretical explanations may need to be tempered by the problem of matrimonial selection. Essentially, this argument suggests that the probability of psychiatric problems or suicidality among those entering into marriage is lower than among those who are not married, and those who stay in marriages are more likely to be both physically and mentally well, thus suggesting that divorced and separated individuals are at an elevated risk irrespective of such life events (Smith et al., 1988). Yet while the problem of matrimonial selection indicates a need to conduct further research regarding the interaction of mental health and marital status, there is arguably enough evidence to suggest that higher mortality in divorced or separated individuals is independent of initial morbidity – and hence this selection mechanism is not the only factor that explains the relationship between suicide and marital status (Burgoa et al., 1998).

As noted in Courtenay's (2011) review of evidence on men's health, marriage is associated with a wide range of health gains for men and women, but the

health risks of being unmarried are greater for men. We now devote a substantial section of the paper to discussing the gender differential in suicide risk when intimate relationships fail.

Why the apparent gender differential in suicide risk when intimate relationships end?

Various theories have been put forward by the authors of the reviewed papers to explain the differential effect of relationship breakdown on men and women, although, as noted above, these theories are not empirically tested. There are also other relevant bodies of social science research and theory which can potentially help illuminate this issue of gender difference. One promising avenue is qualitative research on the circumstances of relationship breakdown and gendered responses. An example of this is the study of 100 coroners' case files by Shiner et al. (2009). This study identified cases (n=34) where the suicide seemed to have been primarily triggered by relationship breakdown and constructed five different categories to describe the psychosocial context of the suicidal act: murder/attempted murder, punishment, over-dependence, sexual jealousy and separation from children. The categories of murder/attempted murder, punishment and separation from children were exclusively male and the category of sexual jealousy very largely male. In all categories of cases there were gendered features; that is, cultural associations with masculinity and femininity could be observed in the ways partners related to each other and interpreted each others' actions. We return to some of these categories in the sub-sections below. More qualitatively-driven work such as this is much needed and ideally we would hope to see the testing of inductive categories from qualitative research on suicide cases in larger samples. Qualitative work allows researchers to get beyond a simple sex group binary of comparing men with women and instead to consider a diverse range of masculinities (Scourfield, 2005; Canetto & Cleary, 2012). However, there is still some worth in sociological generalisation about typical differences between men and women. In the following sub-sections, conceptual themes have been identified which hold some promise for theorising gender differentials in suicide risk when relationships fail.

Marriage as a more positive experience for men than women

Some arguments centre on the supposition that men derive more benefit from marriage than women, and that being married entails more distress for wives than husbands (Durkheim, [1897] 2002; Trovato, 1991). Trovato (1991) notes that wives report more psychiatric disorders than husbands, whereas in the unmarried population men tend to have a higher level of distress and psychiatric disorders. McMahon (1999) has described how the relatively recent model of 'new' men who share domestic responsibilities equally with women is an ideal rather than a day-to-day reality, with most men still expecting to be taken care of within intimate relationships.

Men's inflexible roles and loss of honour

Traditional constructs of masculinity can be seen to cause problems for men's mental health (Courtenay, 2011). Stack's research review (2000b) notes that one of the reasons given by social scientists for suicide being more common in men than women is that men's social roles are inflexible when compared with women's, with women typically adapting to a number of different roles over the life course. The assumption is that role inflexibility leads to emotional distress. If so, then a mediating factor may be loss of honour, leading to shame. According to Bourdieu (2001, p. 50), honour is 'a system of demands which remains, in many cases, inaccessible'. It requires public affirmation and validation 'before other men' (Bourdieu, 2001, p.52). Scourfield (2005) has applied the idea of honour to men's suicide, in circumstances where there is an overt and publicly acknowledged gap between the culturally authorised ideal of 'hegemonic masculinity' (Connell, 1995) and the grim reality of life for men in crisis, so that a life without masculine honour is not seen as a life worth living. Amongst the inflexible roles that are required for masculine honour are those of boyfriend, husband and father. It may be, then, that relationship breakdown is perceived as more of a failure by men than women,

although it should be noted that Kõlves et al. (2010) found a significant relationship between separation-related shame and suicide in both men and women.

The changing nature of intimacy

Some social theorists have claimed that the 'pure relationship' is increasingly idealised in late modernity (Giddens, 1992), with expectation that committed sexual partners will also be emotionally close and will communicate on a close personal level. Love, according to Beck and Beck-Gernsheim (1995, p. 179), is the 'new secular religion'. Changing expectations of intimacy will affect both men and women, but, according to Whitehead (2002), the idea of love goes against the self-sufficiency that is expected of men, so the idea of the pure relationship 'does not work, either as theory or practice, unless men change' (p. 160). Whitehead further argues that the pressure of the pure relationship ideal will only lead to disappointment and 'serve to increase, rather than resolve, existential angst' (p. 161). It may be that, when expectations of intimacy are increased but relationships fail, men are more likely to have a self-destructive reaction.

The increasing importance of the care of children

Dominant discourses of fathering are shifting, even if practice is slow to change (Lupton & Barclay, 1997). The importance of men's hands-on involvement in the care of children is increasingly emphasised, even though older discourses of men as providers have not faded (Shirani et al., 2012). In their qualitative research, Shiner et al. (2009) found that separation from children was cited as a factor in a number of coroners' suicide inquests and men's separation from children seemed to be the primary causal factor in some cases. Disputes over the care of children post-separation can result in anger at court systems perceived to favour the interests of women (Kposowa, 2003). Kõlves et al. (2010) have noted that the legal negotiations associated with separation can be stressful experiences. They found that men who perceived legal negotiations and property/financial issues as stressful were more likely to have serious suicidal ideation, while this same risk was not found with separated women. An additional issue related to the care of children is that, if mother and children remain in a family house post-separation, a father may be displaced from a 'home' to more unstable accommodation. North and Smith (1993) found men more than twice as likely as women to cite divorce as a trigger for homelessness and suicidal ideation is, according to Fitzpatrick et al. (2007), 10 times more common in homeless people than in the general (US) population.

Control in relationships

The research by Shiner et al. (2009; see also Fincham et al., 2011) found that evidence of actual or attempted control of partners was present in many suicides in men which were triggered by relationship breakdown (the majority in their small sample could be put into the category of domestic abuse). There were impulsive reactions to ex-partners starting new relationships and also some cases of suicidal acts ostensibly being meant to punish ex-partners, with some examples of vituperative suicide notes. It is important to note that some self-destructive acts are at least partly motivated by the expected effect on others. These cases need to be put in the context of what we know about domestic abuse and the high prevalence of men's controlling behaviours in intimate relationships (Dobash & Dobash, 1992).

Men's social networks

Men's friendships are important to consider, as they can become particularly important when an intimate relationship breaks down. Joiner (2011) has presented considerable evidence about the loneliness of men. Even where men have a good number of social contacts, the quality of these relationships might be such that these men could still be considered lonely. He notes that many men do not realise they are lonely, preoccupied as they are with work, but in difficult times, for example when a marriage fails, they might be suddenly struck by their lack of meaningful social support. Kposowa (2000) notes that women have more supportive networks and meaningful friendships to support them after relationship dissolution. Canetto's (e.g. 1997) work on gendered cultural scripts of suicidality is generally relevant to understanding gender

differences in suicidal behaviour. She notes the evidence that suicidal reactions to relationship breakdown are popularly associated with women and femininity. This might suggest that men will tend to be reluctant to disclose to friends their distress about the ending of a relationship.

Variations between men in suicide risk when intimate relationships end

Only three studies compared separation with divorce, but all of these showed a higher risk for separation than for divorce. Evidence on this comparison is limited, but if this finding were to be repeated in subsequent studies, it may be that the timing of the relationship breakdown is a factor which can explain the difference in risk. Divorce necessarily follows separation, so more time has elapsed since the relationship failure. It may be that emotional crisis following separation is likely to dissipate over time. For example, an impulsive suicidal act in response to the news of an ex-partner's starting a new relationship with someone else (see Shiner et al., 2009) is arguably more likely when the split is more recent.

The evidence is equivocal about which stage of the life course sees the greater gender differential, but four of the six studies with appropriate analyses of age found higher suicide risk in mid-life when relationships end. Shiner et al. (2009) focus on the combined pressures of work and family responsibilities in mid-life. These are social factors which tend to protect against a range of problems, including mental illness, but their loss (actual or threatened) can cause acute distress. Joiner (2011) highlights men's loneliness in middle age. He describes a process whereby younger men focus on material gain and status rather than nurturing their various social relationships. By the time middle age arrives, many men have become socially and emotionally isolated.

The review did not find suitable analyses of variation by socio-economic status. We know, however, that many suicidal acts occur in the context of a cluster of difficult circumstances which compound each other (Fincham et al., 2011). We might therefore expect that, for men living in materially difficult circumstances or experiencing challenging economic events such as unemployment or debt, the impact of a relationship breakdown might be more severe. Indeed, a relationship breakdown can itself contribute to a change in economic status, such as loss of housing, debt or unemployment. The divorce rate is higher amongst economically vulnerable people, such as those on benefits, unemployed or experiencing financial difficulties (Kiernan and Mueller, 1998). There does not seem to be evidence to date as to whether or not this higher divorce rate is associated with suicide risk in men who are economically marginalised.

However, it should be noted that the social and cultural aspects of masculinity summarised in the previous section will impact differently according to social class and economic circumstances. Connell's (1995) concept of 'marginalised masculinity' describes the identities and practices of men who aspire to the culturally authorised ideal of 'hegemonic masculinity' but find that their social and economic circumstances block the fulfilment of their aspirations. For men in working class jobs, a low income, precarious employment and lack of occupational status can be a challenge to masculine honour. For those out of work, the challenge to honour could be even greater. In this context, social status as husband / boyfriend and /or father can be protective. A failed relationship, however, can be the straw that breaks the camel's back. For some it can be the tipping point from psychosocial survival into crisis.

Limitations of the review

One of the central limitations of this study is the difficulty of disentangling the risk of suicide according to different relationship types. Studies tend to combine divorce and separation, which, as shown above, carry different suicide risks. Moreover, several studies which were excluded from this review combine these two terms with widowhood and never married, which are very different phenomena. The inclusion of these factors (particularly widowhood) can conclude in the over-reporting of suicide risk, or the misrepresentation of

the gender differential. For example in the discussion of Masocco et al.'s (2008) paper, the authors suggest that males are a higher risk of suicide than females, but if this analysis is limited to divorce/separation, it is apparent that females have the higher risk (OR=2.77) compared to men (OR=1.63).

As noted earlier in the paper, while it is common to present separate analyses of the impacts of divorce/separation by sex, the statistical interaction between sex and relationship breakdown in influencing suicide risk is rarely assessed. Indeed, some studies conclude that the strength of associations differs between sexes simply on the basis of p-values. However, these values are likely to be lower among male samples even where relative risk is the same, due to higher overall rates of suicide among males. Hence, we have only included studies which report risk ratios or coefficients from statistical tests. Studies relying upon analysis of trends at the cluster level (e.g. comparing divorce rates with suicide rates) are potentially subject to the ecological fallacy. In addition, most studies do not adjust for social and economic factors which potentially confound the relationship between suicide and relationship breakdown.

There is inconsistent reporting of marital categories which makes it difficult to compare findings across studies. There is perhaps an undue focus on marriage when so many important relationships take place outside of marriage. Another limitation is that the literature around intimate relationships and suicide is seemingly hetero-normative and does not consider same sex relationships/ partnerships/ marriages. Additionally, from a UK perspective there is not enough UK-based research, with only two studies being included in our review.

Conclusion

Of the studies included in the systematic review, most (17/25) found a higher suicide risk for men than for women in the context of either divorce or separation (individual-level studies) or rising rates of these in the population (for ecological studies). It is important to note, however, that 12/25 studies found either no gender differential or a higher risk for women, so there can be no decisive conclusion here. Taking the dominant finding of higher risk for men, the paper included some discussion of possible reasons for this, focusing in particular on the contribution of the wider social science literature to understanding this gender differential. Some psychosocial issues were highlighted which could potentially inform the development of interventions to prevent suicide in the context of relationship breakdown. The issues of particular relevance to prevention would seem to be men's role inflexibility, the increasing importance of the care of children, men's desire for control in relationships and men's social networks; possible interventions related to these issues are suggested below.

One clear implication of the evidence that relationship breakdown is associated with heightened suicide risk is that, when working with men and women already identified as at risk of suicide, practitioners need to be alert to the possibility that relationship breakdown can be a trigger to suicidal acts. There are also possible implications for a more population-based public health approach. One idea would be the promotion and greater free provision of services, such as relationship counselling and mediation, which mitigate the most damaging aspects of relationship breakdown. Some relationships could be maintained with help from a counsellor or mediator. There are others which inevitably will come to an end, but that ending could be eased with a third-party mediator to help negotiate the process. This can be especially helpful when there are disputes over the care of children.

There is also room for social and educational programmes which encourage critical reflection on gender role socialisation (see Featherstone, Rivett and Scourfield, 2007). There is a particular opportunity to develop these for young people, in schools, colleges and youth clubs. An emphasis on encouraging boys and men to disclose distress to friends and family is one aspect which could help protect against suicidality. Another, more specific to men and to relationship breakdown, is an emphasis in interventions on questioning the need for control in intimate relationships.

Further research is also needed on this issue and especially on the psychosocial circumstances of suicidal acts. To get beyond the sometimes crude categories of married/separated/divorced would seem to be an important priority for researchers. This will inevitably necessitate mixed methods approaches.

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Endnotes

1. This concept, from Durkheim ([1897]2002) refers to suicide which is explained by lack of social integration and an excess of individuation, with the individual cut off from other community members.
2. Another one Durkheim's ([1897]2002) categories was 'anomic suicide', caused by a moral confusion, where there is a lack of moral regulation in society.

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Appendix A: **Inclusion and exclusion criteria for systematic review**

Inclusion criteria	Exclusion criteria
1. Published since 1970 2. Peer reviewed journal articles 3. Studies from within OECD countries 4. Studies with a relevant suicide outcome, including suicide risk, suicidal ideation, suicidal behaviours, attempted suicide, and completed suicide 5. Studies with a relevant measure of intimate relationships as a cause of suicide, including divorce, separation and relationship breakdown 6. Studies that explore the relationship between suicide (and related outcomes) and divorce (and related outcomes) 7. Studies that focus on the general population.	1. Studies from non-western countries, i.e. whose without roots in Europe, e.g. Japan, China, India, Taiwan 2. Evaluations of interventions 3. Studies that do not include a relevant suicide-related outcome 4. Studies that examine euthanasia or assisted suicide 5. Studies that have an exclusive focus on deliberate self-injury not designed to threaten life 6. Studies that focus on broader familial relationships 7. Studies that focus on parental divorce or separation as a cause of suicide 8. Studies that focus on the loss of a child/ child suicide 9. Studies that focus on population subgroups – imprisoned, schizophrenics, dentists, police, and psychiatric inpatients 10. Studies that examine suicide (and related outcomes) and marital status (and related outcomes) as two separate factors that influence a third measure e.g. HIV, cocaine use, PTSD 11. Studies that focus on genetic testing 12. Studies that validate a measure/scale 13. Studies that are not in the English language 14. Studies that explore fictional portrayals of suicide e.g. film and novels 15. Studies that are therapy-based and discuss individual cases or advise on therapeutic practice 16. Studies that exclusively consider suicide and widowhood 17. Studies with no inferential statistics 18. Studies that create a relationship binary of married/non-married 19. Studies that combine divorced/ separated with widowhood and/or never married.

Appendix B: Papers selected for review (individual-level analysis)

Study	Country	Data source	Sample size/description	Outcome measure	Comparison (reference category bold)	Statistical method	Male only analysis	Female only analysis	Male/female comparison /interaction	Covariates
Zeiss, Zeiss & Johnson (1981)	USA (Oregon)	Cases randomly selected from courthouse divorce files and surveyed	N=133	Suicidal feelings	**Divorced men** vs divorced women	T-test	n/a	n/a	t=2.23 (p=0.05) Significantly fewer suicidal feelings amongst women	n/a
Trovato (1991)	Canada	Mortality Data Base 1951-1981	N= 1951=5388150 1961=6949016 1971=8249033 1981=10398940 Age=35+	Suicide	**Married** vs divorced/separated	Logistic regression	1951: RR=1.63 1961: RR=1.75 1971: RR=1.80 1981: RR=1.67	1951: RR=1.59 1961: RR=1.68 1971: RR=1.81 1981: RR=1.61	Difference Male –Female RR 1951 RR=0.04 1961: RR=0.07 1971: RR=-0.01 1981: RR=0.06	None
Rodriguez-Pulido et al. (1992)	Canary islands	Review of judicial proceedings	N=775 suicides (denominator total population as of 1981)	Suicide rates	Single, married, widowed, separated /divorced	Chi-squared	X^2=411.4 (p<0.001) Married men 13.95 suicides per 10,000 Divorced men 112.37 suicides per 10,000	X^2=161.2 (p<0.001) Married women 4.11 suicides per 10,000 Divorced women 35.34 per 10,000	n/a	n/a
Cantor & Slater (1995)	Australia	Queensland Suicide Research and Prevention Program's Suicide Register and Register General's Record 1990-1992	N=1375 suicides (denominator= Queensland population); Age= 15+	Suicide	**Married** vs separated	Simple relative risk ratios (suicide rate/suicide rate for ref category)	Age= 15+: RR=6.2 Age=15-29: RR=6.1 Age=30-54: RR=7.6 Age=55+: RR=3.2	Age= 15+: RR=1.6 Age=15-29: RR=1.9 Age=30-54: RR=1.9 Age=55+: RR= -	n/a	None
					Separated vs divorced		Age= 15+ RR=0.5 Age=15-29: RR=0.3 Age=30-54: RR=0.5 Age=55+: RR=0.5	Age= 15+: RR=2.0 Age=15-29: RR=0.8 Age=30-54: RR=1.6 Age=55+: RR= -		
Heikkinen & Lonnqvist (1995)	Finland	National Suicide Prevention Project 1987-	N=1022 Age=20-88	Suicide	Life events (separation; family discord)	Chi-square	n/a	n/a	Male and female difference in frequency of separation or family discord during 3 months	None

		1988							prior to suicide not significant for 20-59 yr olds or ≥60 yr olds.	
Burgoa et al. (1998)	Spain	National Institute of Statistics (INE) Death Registry 1991	N=Unknown; Age=25+	Suicide	**Married** vs divorced/separated	Poisson regression	RR=2.99 (95% CI=2.26-3.97)	RR=1.50 (95% CI=0.84-2.67)	n/a	n/a
Kposowa (2000)	USA	National Longitudinal Mortality Study (NLMS) 1979-1989	N=545, Age=15+	Suicide	**Married** vs divorced	Cox proportional hazards regression	RR=2.38 (95% CI=1.77-3.20)	RR=1.27 (95%CI=0.67-2.41)	n/a	Age, race, sex, education, income, region of residence
Cutright & Fernquist (2005)	USA	General Social Survey	N=54 clusters (age*sex*marital status) White population	Suicide rate	Married vs **divorced** (20-34 year olds)	Standardised suicide difference coefficient	-0.61 (1979) -0.64 (1992-94)	-0.61 (1979) -0.64 (1992-94)	n/a	n/a
					Married vs **divorced** (35-54)		-0.61 (1979) -0.60 (1992-94)	-0.49 (1979) -0.54 (1992-94)		
					Married vs **divorced** (55+)		0.51 (1979) -0.53 (1992-94)	-0.43 (1979) -0.50 (1992-94)		
Agerbo (2005)	Denmark	The Danish Medical Register on Vital Statistics 1982-1997	N=1892311, Age=25-60	Suicide	**Married living with spouse** vs divorced	Logistic regression	IR=1.75 (95%CI=1.58-1.95)	IR=1.68 (95%CI=1.46-1.95)	n/a	Age, time since last discharge from psychiatric impatient care, psychiatric disorder to latest discharge, death amongst children; number of children; Income, labour market affiliation in previous year, education
					Married living with spouse vs separated		IR=1.93 (95%CI=1.67-2.23)	IR=1.97 (95%CI=1.58 - 2.45)		
Fekete et al. (2005)	Hungary	University Clinics, Pecs Center 1997-2001	N=1158 suicide attempts Females: 63% Males: 37%	Gender (among suicide attempters)	**Married** vs divorced	Logistic regression	n/a	n/a	OR=1.64 (95%CI=0.84-3.21)	None

			Age=25-90							
Masocco et al. (2008)	Italy	Italian Database on Mortality 2000-2002	N=2784 suicides Age= 25+	Suicide (compared to natural causes)	**Married** vs divorced/separated	Logistic regression	Age 25-44 OR=1.63(95%CI=1.25-2.13) Age 45-64 OR=1.88(95%CI=1.59-2.26) Age 65+ OR=1.65 (95%CI=1.21-2.27) All OR=1.79 (1.57 to 2.05)	Age 25-44 OR=2.77(95%CI=1.95-3.94) Age 45-64 OR=1.69(95%CI=1.27-2.25) Age 65+ OR=1.79(95%CI=1.15-2.78) All OR=1.96 (1.61 to 2.39)	n/a	None
Cupina (2009)	New Zealand	Auckland Community Crisis Team Clinical File 2007	N=442 Age=18-65	Suicidal ideation/ attempts	Gender differences in reasons for suicidal behaviour (including separation from partner and relationship conflict)	Chi-square	n/a	n/a	X^2 -0.54, df=1, p=0.46	None
Denney et al. (2009)	USA	National Health Interview Survey Linked Mortality File	N=1055943 53.5% female Aged=18+	Suicide	**Married** vs divorced/separated	Cox hazards model	1.39 (p<0.05)	1.42 (p>0.05)	(X2=36.0, df=3, p<0.01)	Race, family size, SES, geographic area, health status
					Married vs never married		1.22 (p<0.05)	1.34 (p>0.05)		
					Married vs widowed		1.60 (p<0.05)	1.18 (p>0.05)		
Petrovic et al. (2009)	Serbia	Regional Statistics Centre, Nis 1995-2002	N=628 suicides Age=20+	Suicide	**Married** vs divorced	Relative risk ratios (with 95% CI) and chi-square	RR=3.79 (95%CI=2.54-5.63)	RR=1.47 (95%CI=0.74-2.82)	n/a	Unclear
Walsh et al. (2009)	USA	Kentucky Violent Death Reporting System Database 2005	N=557 suicides Males=451 Females=106	Suicide	Intimate partner problems	Chi-square	n/a	n/a	Departure of an intimate partner cited as a factor in significantly more male than female suicides(p<0.0001)	None
Kolves et al. (2010)	Australia	Contacted counselling, help-lines, support groups 2006-2007	N=370 Male (N=228) Female (N=142)	Suicidal ideation	**Separated males** vs separated females	Logistic regression	n/a	n/a	Felt life was not worth living (OR=1.81, 95%CI=1.14-2.87); Wished I was dead (OR=1.10, 95% CI=0.70-1.75); Thinking about taking own life even if would not really do it (OR=1.95, 95%CI=1.23-3.10); Thought serious about committing suicide	Age, education, employment, having children with previous partner

									(OR=1.86, CI=1.04-3.32); Made plans for committing suicide (OR=2.06, 95%CI=1.02-4.14); None of the above (OR=0.59, 95% CI=0.37,0.95); Attempted to take own life (Fisher's exact test=0.055)	
Masocco et al. (2010)	Italy	Italian Database on Mortality 2000-2002	N=Unclear Age= 25+	Suicide (compared to natural causes)	**Married** vs divorced/separated	Logistic regression	Age 24-44: OR=1.47(95%CI=1.12-1.91) Age 45-64: OR=1.77(95%CI=1.49-2.12) Age 65+: OR=1.61 (95%CI=1.18-2.21)	Age 24-44: OR=2.67(95%CI=1.88-3.81 Age 45-64: OR=1.62(95%CI=1.22-2.17) Age 65+: OR=1.72(95%CI=1.11-2.68)		Region of residence
Corcoran & Nagar (2010)	Northern Ireland	General Register Office (GRO for Northern Ireland 1996-2005	N=1398 suicides Age=20+	Suicide	**Married** vs divorced	Poisson regression	Age=20+: IRR=2.61 (95% CI=1.39-4.88) Age=20-34: IRR=2.14 (95%CI=0.99-4.61) Age=35-54: IRR=0.91 (95%CI=0.45-1.84)	Age=20+: IRR=2.57 (95%CI=0.89-7.42) Age=20-34: IRR=3.68, (95%CI=0.91-14.86) Age=35-54: IRR=1.09 (95%CI=0.35-3.48)	n/a	None
Kovess-Masfety et al. (2011)	Spain and France	European Study of the Epidemiology of Mental Disorders (ESEMeD) 2001-2003	N=21425 Age=18+	Suicidal ideation	**Married** vs separated/ widowed/divorced	Logistic regression	France: OR=1.43 (95%CI=0.39-5.32) Spain: OR=1.68 (95%CI=0.42-6.66)	France: OR=0.96 (95%CI=0.55-1.68) Spain: OR=1.14 (95%CI=0.60-2.17)	n/a	Unclear

Appendix C: **Papers selected for review (cluster/ecological level analysis)**

Study	Country	Data source	Sample size/description	Outcome measure	Comparison (reference category bold)	Statistical method	Male only analysis	Female only analysis	Male / female comparison / interaction	Covariates
Lester (1992)	Australia	Australian Bureau of Statistics 1966-1985	N=20 clusters (years)	Suicide rate	n/a	Pearson correlation and linear regression	Divorces> marriages associated with lower suicide rate (r= -0.26, NS) B=0.001(NS) (after adjustment for unemployment and alcohol consumption)	Divorces> marriages associated with a lower suicide rate (r=-0.79, p<0.001) B=0.005(NS) (after adjustment for unemployment and alcohol consumption)	n/a	None
Rossow (1993)	Norway	Central Bureau of Statistics 1911-1990	N=80 clusters (years)	Suicide rate	**Divorced**	Time-series regression analysis	r=0.35 (SE=0.17) P<0.05	r=0.25 (SE=0.29), p=NS	n/a	None
Burnley (1995)	Australia	Australian Bureau of Statistics 1986-1989	N=1360 suicides Age=25-64	Suicide rate	**Divorce/separation rate and suicide rate**	Pearson's correlation	Age=15-24 r=0.52 (p<0.01) Age=25-39 r=0.53 (p<0.01) Age=40-64 r=0.56 (p<0.01) Age=65-74 r=0.45 (p<0.01)	Age=15-24 r=0.26 (p>0.05) Age=25-39 r=0.52 (p<0.01) Age=40-64 r=0.28 (p>0.05) Age=65-74 r=0.38 (p<0.05)	n/a	Standardized mortality ratios
Lester (1995)	USA	National Center for Health Statistics 1980	N=36 clusters (states)	Suicide rate	**Divorced grooms/brides** vs overall suicide rate	Pearson's correlation	r=0.42 (p<0.01)	r=0.50 (p<0.001)	n/a	None
Gunnell et al. (2003)	UK	Office of National Statistics 1950-1998	N=47 clusters (years) Age=25+	Suicide rate	**Divorce rate** vs suicide rate	Cochrane-Orcutt regression	Age=25-34: +ve association (p<0.05) Age=60+: p>0.05	Age=25-34: -ve association (p<0.05) Age=60+: p>0.05	n/a	None
Andres (2005)	15 European countries	World Health Organisation database	N=236 country/year clusters	Suicide rate (age adjusted rate per 100,000 of population)	Association between divorce rate and suicide rate	Linear regression	B=0.11 (p<0.01)	B=0.03 (p>0.10)	n/a	Gini index GDP per capita Economic growth Unemployment rate Fertility rate Female labour participation rate Alcohol consumption

										Country Year
Barstad (2008)	Norway	Statistics Norway published suicide figures	N=57 clusters (years 1958 to 2004)	Suicide rate	Association between separations per 1000 and suicide rate per 100,000	Box-Jenkins time-series analysis	0.42 (0.29 to 0.55)	0.25 (0.03 to 0.47)	n/a	n/a
					Association between divorce rate per1000 and suicide rate per 100,000		0.18 (-0.08 to 0.44)	0.04 (-0.28 to 0.36)		
					Association between marriage rate per 1000 and suicide rate per 100,000		-0.08 (-0.12 to 0.04)	-0.08 (-0.18 to 0.02)		
Andres & Halicioglu (2010)	Denmark	Denmark Statistical Bank	Unclear	Suicide rate	Association between divorce rate and suicide rate	Autoregressive distributed lag model	0.33 (-0.62 to 1.28)	0.16 (-1.08 to 1.41)	n/a	Per capita income, employment rate, fertility rate
Fernquist (2010)	21 developed countries	Official government statistics from 21 countries	N=168 clusters (21 countries at an average of 8 time points per country)	Suicide rate	Association between divorce rate and age-standardised suicide rate in high and low religion countries	Linear regression (standardised beta)	High religion countries B=0.53 (p<0.01) Low religion countries B=0.02 (p>0.05)	High religion countries B=0.45 (p<0.01) Low religion countries B=-0.09 (p>0.05)	n/a	Religious books Fertility rates GDP/C annual % change Collectivism
					Association between divorce rate and age-standardised suicide rate in high and low divorce countries		High divorce countries B=0.15 (p<0.05) Low divorce countries B=0.22 (p<0.05)	High divorce countries B=0.05 (p>0.05) Low divorce countries B=0.20 (p<0.05)		
Agerbo et al. (2011)	Denmark	Linkage of Danish Government statistics on suicide and number of unemployed	N=88023 suicides (33.5% female) covering 432 million person-years	Suicide rate	Increase in suicide rate with number of divorces	Poisson regression	1% increase in divorce associated with 0.52% increase in suicide rate	1% increase in divorce associated with 1.12% increase in suicide rate	n/a	n/a
					Increase with number of marriages		1% increase in marriage associated with 0.77% increase in suicide rate	1% increase in marriage associated with 1.63% increase in suicide rate		

Men, suicide and society: the role of psychological factors

by Olivia Kirtley and Rory O'Connor

Abstract

The aim was to review psychobiological, cognitive and personality evidence and interpret this within the Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV) (O'Connor, 2011), in order to provide a psychological explanation for the high rate of suicide seen in men of low socio-economic status in mid-life. A literature review was conducted on the psychobiological, cognitive and personality variables identified within the IMV model, for evidence relating to males in mid-life, of low socio-economic status. In addition, analyses were carried out upon an existing dataset, using information from 227 males admitted to hospital following an episode of self-harm. Demographic, clinical and psychological information was collected from all participants. There is a dearth of psychological literature relating to this population, with little or no research within the field of suicide research giving substantial focus to age or gender (as opposed to simply controlling for it). The stress of socio-economic deprivation, particularly unemployment, appears to play a key role in suicidal behaviour within this population. Psychological distress as a result of financial difficulties or being unable to provide for dependents may be amplified by males' elevated response to achievement stressors. Our data analyses showed unemployed males displayed higher levels of socially prescribed perfectionism and generated fewer effective solutions to social problems, than males in work or training. Social difficulties may result in problems at work, affect relationships and contribute to a lack of social support, which in turn increases risk of suicidality. Psychobiological evidence suggests that under stress, males engage in more risk-taking behaviour and have a higher threshold and tolerance for physical pain, which may increase the likelihood of (lethal) suicidal behaviour. Interventions to target socially prescribed perfectionism and social problem-solving in this group of men should be developed. More careful attention should be paid to individuals' life circumstances at the point of contact with psychiatric or support services.

Introduction

The current report reviews and integrates psychobiological, cognitive and personality evidence in order to attempt to provide an explanation for the high rate of suicide observed in mid-life men of low socio-economic status. We explore the psychological factors such as stress response mechanisms, personality and cognitive characteristics which may lead men in mid-life to be at elevated risk of taking their own lives. We also present analyses from an existing dataset which focuses on some of the psychological factors described herein. The findings from our review are interpreted (where appropriate) within the Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV) (O'Connor, 2011).

Our report has two components: a review of the extant literature on suicidal behaviour and the analysis of an existing primary dataset; the results of the literature review are presented first, followed by the results from the primary data analyses. As the findings from the report are considered within the framework of the IMV model, we will first briefly introduce the model (see Figure 1). The results of the literature review are organised according to the phase of the model into which they fit.

The Integrated Motivational-Volitional Model of Suicidal Behaviour

A new model of suicidal behaviour proposed by O'Connor (2011), the IMV model, helps us understand why some people become suicidal and others do not, as well as determining who is more likely to act on thoughts of suicide by attempting suicide. In recognition of the complex pathway to suicide, the model, shown in Figure 1 on the following page, is tripartite, comprised of pre-motivational, motivational and volitional phases.

The pre-motivational phase is based upon a diathesis-stress paradigm, whereby intrinsic factors such as genes, other biological elements or personality factors, such as perfectionism, result in an underlying vulnerability to suicide risk that is activated by psychological and/or social stress, for example, loss of a loved one, or environmental stress, such as deprivation.

The motivational phase incorporates the cry of pain model of suicide (Williams, 2001), which contends that the risk of suicide is particularly proximal when defeat and entrapment are experienced. Moderating the pathway between defeat and entrapment are factors termed threat-to-self moderators (TSM); these include social problem-solving and dysfunctional thinking style (rumination). According to the model, the presence of TSMs increases the likelihood that defeat is translated into feelings of entrapment. The likelihood of those experiencing entrapment becoming suicidal is influenced by motivational moderators (MM); the latter include propensity for goal re-engagement, with evidence suggesting that suicide attempters who disengage from unattainable goals and who fail to re-engage in new goals exhibit significantly higher suicidal ideation at follow up than those who re-engage in new goals (O'Connor et al., 2009; O'Connor et al., 2012).

Access to the means of suicide and capability (to engage in suicidal behaviour; Joiner, 2005) are volitional moderators (VM), and it is these factors that differentiate between those who ideate about suicide (ideators), and those who will move into the final volitional phase of the model, whereby a suicide attempt is made (enactors).

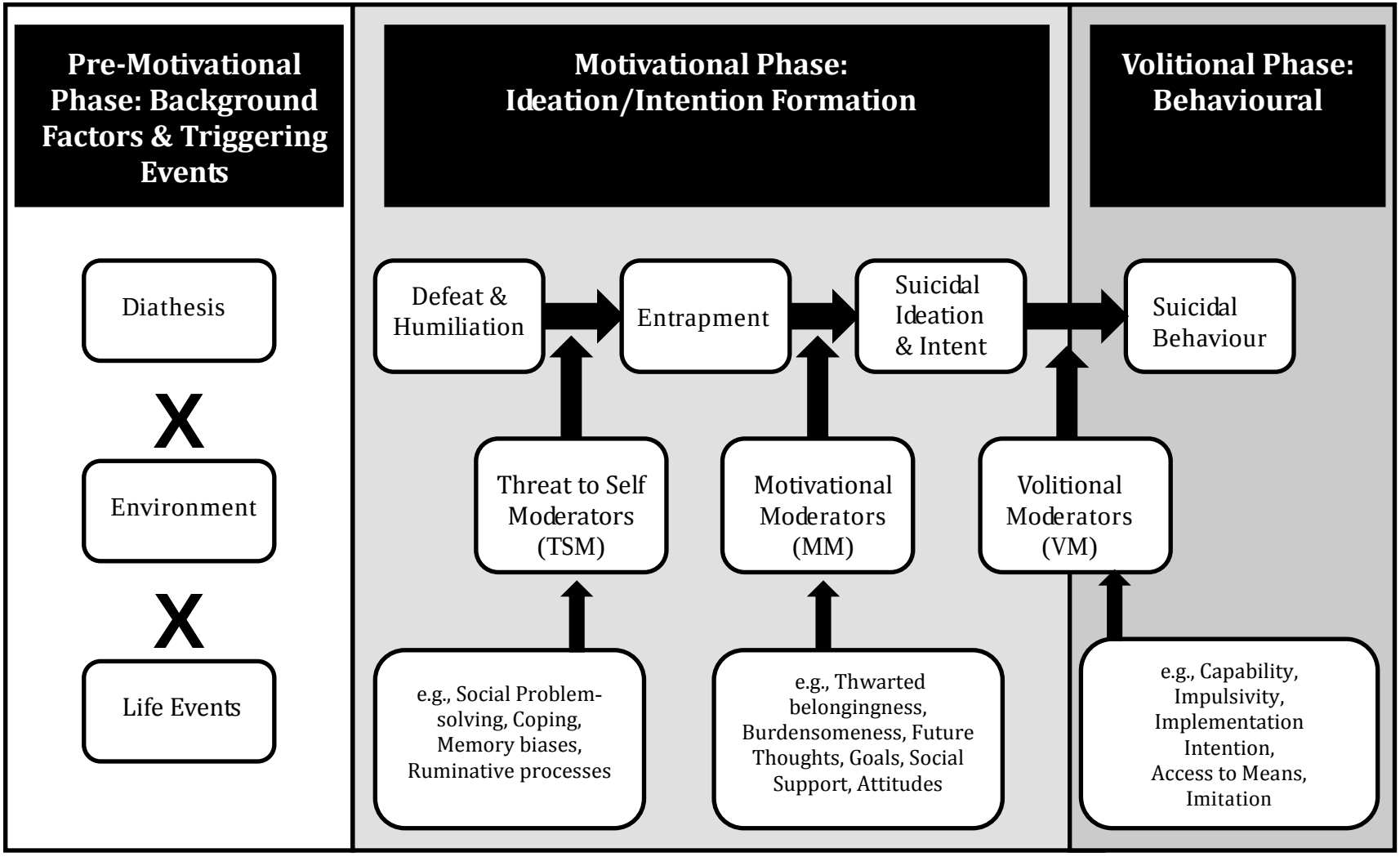
It should be noted that a factor may be involved at multiple phases within the model and that those factors described above are examples of the factors that act as moderators, and this is not an exhaustive list.

Literature review

A literature review of the three major psychological and medical databases was conducted: PsycINFO, Medline and Web of Knowledge, with a search window of 1990 to the present. The following search terms were employed: suicid* OR self harm OR self injur* AND (1) gender OR sex; (2) social class OR socio-economic; (3) employment. The latter three terms were taken to be approximations of socio-economic status. Additionally, a list of other search terms was generated, based upon the IMV variables identified in the original version of the model (O'Connor, 2011): perfectionism; psychiatric disorder OR psychiatric diagnosis; self critic*; problem solving; memory; ruminat*; future thoughts OR future thinking OR future orientation; social support; marital status OR relationship; burden*; belong*; imitat*; capability and impulsivity. Studies were included if they were published in peer reviewed journals and published in the English language. A further filter was applied to only return results which included participants in their thirties (30–39) and middle age (40–64). The reference lists of studies found via the databases were also hand-searched, in order to minimise the chance of missing relevant literature.

With particular regard to the psychobiological literature, additional studies which were already known to be relevant by the authors were also included. Much of the psychobiological research examining gender differences has utilised samples composed of undergraduate students; where no equivalent research could be found which used the target mid-life age group, these studies have still been included, as they may inform future directions for research.

Figure 1. **Integrated Motivational –Volitional Model of Suicidal Behaviour** (O'Connor, 2011)



Unless explicitly mentioned, the studies included in the literature review did not specifically explore age or gender as a variable; however if the mean age of the sample fell with the focus of this report, i.e., between 30–60 years of age, the study was included here. However, the limitation of such studies is that they cannot be used to infer a particular risk by age and gender, relative to other groups.

Due to the timescale, a full systematic review of the literature was beyond the scope of this report and therefore the review results presented here should not be considered to be exhaustive; rather they should be viewed as a detailed overview of the extant research in this area.

Pre-motivational phase variables

Unemployment, low social class, low educational attainment, poor housing, financial difficulties and relationship breakdown and living alone emerge as significant factors and stressors for men in mid-life who become suicidal. However, as these are covered extensively by other contributions to this report, this article restricts its focus to the psychological (and clinical) factors involved in the development of suicidality.

Psychiatric disorder

The evidence for gender differences in the presence of psychiatric disorder in those who have attempted or died by suicide is mixed, with some studies finding no significant gender differences (e.g. Haw et al., 2001; Witte et al., 2009) and others finding females who engaged in suicidal behaviour being more likely to be depressed (O'Connor & Sheehy, 1997) or to have a psychiatric disorder (Haw & Hawton, 2008). Haw et al. (2001) looked at psychiatric disorders in patients presenting to hospital following an episode of self-harm. Of the 150 patients included in this study, 92% had at least one current psychiatric diagnosis, although no significant gender differences were found. However, males were significantly more likely to suffer from alcohol abuse than females.

With regards to age, those with a psychiatric disorder and those between 30–40 years-old have been found to have a higher risk of repeatedly attempting suicide (Haukka et al., 2008). Focusing on completed suicide, however, Snowdon & Draper (2011) found no significant age effects upon diagnosis of depression in a sample of those aged between 35–92 years-old, who had died by suicide in Sydney.

In addition, risk of psychiatric disorder may be linked to employment factors, with men in unskilled and skilled occupations having three times the risk of depression as non-manual workers at five-year follow-up (Kosidou et al, 2011). Further, research by Haw and Hawton (2011) found that both males and females within the 25–54 year-old age group who presented with self-harm were far more likely to have a current psychiatric diagnosis and to have previously received inpatient psychiatric care, if they lived alone, compared to those who lived with others. The comorbidity of psychiatric disorders has also been associated with increased likelihood of repeated attempts (Hawton et al., 2003).

Social perfectionism

Perfectionism, specifically high levels of socially prescribed perfectionism, has been previously demonstrated to confer elevated suicide risk (Hunter & O'Connor, 2003; O'Connor, 2007; O'Connor, D. B. et al., 2007). Social perfectionism can be defined as the perception that one must always meet the expectations of others, with these perceived prescribed standards often being unrealistic (Hewitt & Flett, 1991). Pioneering work by Hewitt et al (1998) found that socially prescribed perfectionism was the only perfectionism dimension to discriminate between people who had attempted suicide and those who did not in a sample of alcohol dependent inpatients; however no gender differences were evident. In a two-month prospective study, high levels of social perfectionism were associated with a poorer outcome in patients admitted to hospital following an episode of suicidal behaviour (O'Connor, R. C. et al., 2007). Social perfectionism was also found to be positively correlated with depression and anxiety in a sample of people whose self-harm was medically serious (Rasmussen et al., 2008). Additionally, having over-general autobiographical memory biases – whereby

recollections are broad and lack specific detail, such as time periods – were found to moderate the relationship between socially prescribed perfectionism and suicidality.

A more recent addition to the perfectionism literature is the concept of perfectionistic self-presentation, which can be defined as the preoccupation with presenting an image of perfection through self-promotion and the concealment of errors from others (Hewitt et al., 2003). As yet, this construct has only been studied in young adults; however the results to date suggest that men score more highly than women on perfectionistic self-presentation (Besser et al., 2010). This may represent an interesting avenue for further investigation in men of low socio-economic status, as factors such as employment or financial problems may cause even greater levels of distress in males who have a tendency towards perfectionistic self-presentation.

Socially prescribed perfectionism has also been associated with a reduced quality of intimate relationships, with males who scored more highly on social perfectionism also using more antagonistic strategies, such as sarcasm, for resolving marital problems (Haring et al., 2003). Haring and colleagues suggest that it is the individual's perception that their partner expects them to be perfect, which may lead them to engage in antagonistic, conflictual responses to problems.

In a systematic review of the perfectionism–suicidality literature, O'Connor (2007) concluded that social perfectionism was a strong differentiator between those with suicidal ideation and those who attempted suicide. Evidence for gender differences in levels of social perfectionism among suicidal individuals is lacking though. The majority of studies included in O'Connor's (2007) review had sampled too few males for reliable statistical analyses of gender differences to be conducted.

Self-criticism

Self-criticism is another type of perfectionism strongly associated with suicidality (O'Connor & Noyce, 2008); it is characterised by excessive negative self-appraisal and an inability to enjoy one's own successes (Dunkley et al., 2006). Campos et al. (2012) reported a significant association between self-criticism and suicidality, which was mediated by level of distress. Self-criticism has also been found to be significantly associated with both current and lifetime suicidal ideation and attempts in a large sample (n=5,877) of adults in the USA (Cox & Enns, 2004). As yet, however, no studies have specifically explored differences in self-criticism as a function of gender, age or socio-economic status.

Gender differences in behaviour under stress and stressor salience

Stress has also been shown to have a differential effect upon men and women, with men engaging in more risk-seeking behaviour after exposure to an acute stressor, whereas women engage in more risk-avoidant behaviour (Lighthall et al., 2009; Preston et al., 2007). Van den Bos et al. (2009) found similar results when examining the relationship between stress response – as indexed by levels of the stress hormone cortisol – and performance on the Iowa Gambling Task (IWG): a neuropsychological test for the assessment of decision making. The results showed that men who had a high cortisol response to a social stress test, subsequently made more risky choices and ultimately performed more poorly on the IWG than women. Lighthall and colleagues (2011) conducted further investigation of the effect of stress upon decision making, finding that men under stress made decisions more rapidly than women.

The increase in risk-taking behaviour among males who are under acute stress may be a factor in the use of more lethal means when attempting suicide (e.g. Varnik et al., 2008). In addition to this, men may make more rapid or impulsive, risky choices generally when under stress, such as drinking more heavily or making rash financial decisions. This could potentially lead to an increase in life problems, such as financial worries, alcohol dependency or relationship issues, which could increase suicide risk.

There also appear to be gender-specific differences in the types of stressors which elicit the greatest responses; men demonstrating a significantly higher cortisol response to achievement-based, as opposed

to socially-based tasks, with the opposite being true of women (Stroud et al., 2002). These findings are consonant with the type of stressors reported by men more generally and those associated with suicidal behaviour in men, such as unemployment (Barth et al., 2011; Blakely et al., 2003), as well as financial and housing problems (Matud, 2004; Windsor et al., 2008; Haw & Hawton, 2008). Perceived control over life events is also an important factor, with men who consider themselves to be more masterful being significantly less likely to attempt suicide (Fairweather et al., 2006). Men who are unemployed or in low-paying jobs may be more likely to engage in suicidal behaviour than women, because these achievement stressors will be more salient for them than for women.

Motivational phase variables

Rumination

Rumination, characterised by frequently recurring, sometimes negative, persistent self-focused thoughts, is another factor which has been associated with suicidal behaviour (Fairweather et al., 2007; Morrison & O'Connor, 2008; Roelofs et al., 2007). It is often divided into two sub-categories, reflection and brooding; with reflection being described as introspective problem-solving, and brooding as passive problem-focused thought, whereby the focus is upon the problem rather than possible solutions (Treynor et al., 2003). The relationship between the pre-motivational variable of social perfectionism and psychological distress, including depression and suicidal ideation, has been found to be mediated by rumination (O'Connor, D. B. et al., 2007); specifically the brooding component of ruminative thought processes.

However, research to date has not found any significant differences in rumination as a result of gender (although very few studies have analysed gender as a variable, as opposed to just controlling for it) (Morrison & O'Connor, 2008). Additionally, to our knowledge, there is as yet no research examining the effect of socio-economic factors or age upon rumination.

Social problem-solving

Reduced social problem-solving ability has previously been identified as a suicide risk factor (e.g., Pollock & Williams, 1998; Pollock & Williams, 2004). For example, Evans et al. (1992) compared a sample of patients admitted to hospital following an overdose and another group of non-suicidal controls, admitted to a surgical ward. Social problem-solving ability was assessed, along with generality of autobiographical memories. Gender was not included as a variable in the analysis; however participants were matched for age and gender. The patients admitted following self-harm or attempted suicide, generated significantly fewer means to solve problems and the means that they did generate were less effective, relative to those generated by controls. Moreover, the nature of the autobiographical memories of the suicidal group was significantly different to those in the control group, with the former displaying an 'overgenerality' (i.e. lacking in specific details). Indeed, Evans and colleagues posit that effective social problem-solving is dependent in part on accessing specific autobiographical memories about previous social situations which were solved in the past.

It is reasonable to extrapolate that impaired ability to solve social problems may impact upon one's employment prospects, with those who struggle to solve social issues that may arise in the workplace, finding it more difficult to remain in work. Furthermore, the greater tendency of males towards a passive problem-solving style, identified by McAuliffe and colleagues (2002; McAuliffe et al, 2006), may mean that important issues are not attended to and problems (e.g. working hours, or salary concerns) are left to solve themselves: another factor which may cause issues for employment. In addition, social problem-solving difficulties may also impact upon an individual's social support resources: social problems between individuals and their friends or family may not be resolved because the person does not know how to approach the resolution of the problem, potentially meaning that the person becomes more isolated. Interestingly, a later study by Pollock and Williams (2004) found that whilst suicidal individuals displayed a more passive style of problem-solving

relative to controls with no psychiatric history, they were not more passive than non-suicidal individuals with a psychiatric diagnosis.

Future thinking

Positive future thinking (PFT) (MacLeod et al., 1997) is characterised as a tendency to feel positively about specific events in the future (Hirsch et al., 2007) and think about positively anticipated events (MacLeod et al., 1997). The relationship between positive future thinking and suicidality has previously been demonstrated to be independent of age and gender (O'Connor et al., 2008). Hopelessness is a global attitude regarding the future and has previously been associated with suicidal behaviour (e.g. Beck et al., 1990). However, it is the inability to generate positive future thoughts, not a greater number of negative thoughts, which is associated with suicidality (MacLeod et al., 1997). PFT was a significantly better predictor of suicidal intent at two-and-a-half month follow-up than global hopelessness in adult suicide attempters (O'Connor et al., 2008).

Positive future thinking is also negatively correlated with socially prescribed perfectionism in patients hospitalised following suicidal behaviour, with participants who scored highly on social perfectionism generating less positive future thoughts than those with low social perfectionism (Hunter & O'Connor, 2003). Later work by O'Connor, R. C. et al. (2007) looked prospectively at the relationship between PFT, suicidality and social perfectionism. Adult participants admitted to hospital following an episode of suicidal behaviour completed the Future Thinking Task, measures of suicidality and social perfectionism. Two months later, repeat self-harmers with low social perfectionism and more PFT were less hopeless at follow-up. These findings support the idea that positive future thinking is a protective factor for suicide and that conversely a lack of positive thoughts about the future could be a risk factor. However, the long-term protective effects are unknown and there is a lack of research examining this.

Once again, there is a distinct lack of research exploring differences in PFT as a function of gender, age or socio-economic status. Further research may also focus on the types of positive future thoughts generated as a function of gender; men exhibit a higher stress response to achievement stressors (Stroud et al., 2002), therefore perhaps a lack of positive future thoughts regarding achievements (e.g. their career), may be particularly distressing.

Thwarted belongingness and perceived burdensomeness

Two further psychological processes which are implicated in the development of suicidal ideation and intent are perceived burdensomeness and thwarted belongingness, defined respectively as feelings of social disconnection and isolation, and the belief that one is so incapable that one is a liability or hindrance to others (Ribeiro & Joiner, 2011). You et al. (2011) investigated belongingness in a sample of adults within residential substance-abuse treatment facilities, finding that thwarted belongingness was a significant predictor of both suicidal ideation and suicide attempt. However, whilst gender was included as a covariate, there were no significant differences as a function of gender, or age. However, research by Davidson et al. (2011) found that males and those of low socio-economic status demonstrated elevated levels of thwarted belongingness and burdensomeness. There is a significant lack of research which explores the effects of age, gender and socio-economic status upon thwarted belongingness and burdensomeness.

Volitional phase variables

Impulsivity

Impulsivity has often been implicated as a risk factor for suicidal behaviour (Gvion & Apter, 2011), although the evidence is mixed (McCloskey et al., 2012). Zouk et al., (2006) investigated impulsivity in a sample of adults who had died by suicide, where measures of impulsivity were available from individuals' medical records. Participants were divided into impulsive and non-impulsive groups and compared on numerous dimensions, including socio-demographic factors, psychiatric disorder, life events and substance abuse. Those in the impulsive group were significantly younger at the time of ending

their lives than those who were not impulsive (37 versus 45 years-old), had completed significantly fewer years of education and also had much lower income. They were also less likely to be in employment or in an intimate relationship at the time of their death than those in the non-impulsive group; however these differences were not statistically significant. In addition, impulsive individuals had a significantly higher prevalence of recent and lifetime drug or alcohol abuse and were more likely to meet the criteria for a Cluster B personality disorder. The likelihood of having experienced a threatening and isolating event, such as having an impending deadline for settling debt, or a separation, was also more likely in those who were impulsive, as well as having an acute trigger event in the week before their suicide. However, as half of the suicide cases examined were those of 'non-impulsive' individuals, consistent with the IMV, impulsivity alone does not determine those individuals who go on to die by suicide.

Interestingly, the impulsivity of the suicide attempt and the individual's trait impulsivity may not always be related, with Baca-Garcia and colleagues (2005) finding no significant association between trait impulsivity and the impulsivity of the attempt. When analysis was conducted to examine possible gender differences, there was a significant correlation suggesting that there may be differences in both state and trait impulsivity as a function of gender. However, the correlation was only marginally statistically significant (p=.05), therefore this finding may be spurious. Later work by Giegling et al. (2009), though, did not find that gender was a significant predictor of the impulsivity of the suicide attempt, therefore the evidence for gender differences in impulsivity are inconclusive and warrant further investigation.

Pain sensitivity

It has been previously demonstrated that men have a higher threshold and tolerance for physical pain than women (e.g. Braid & Cahusac, 2006; Gratz et al., 2011), which may result in the use of more lethal means by men when engaging in suicidal or self-harming behaviours.

Recent research from the field of social neuroscience has examined sensitivity to emotional pain, in the form of social rejection, and its relationship to physical pain sensitivity. Eisenberger et al. (2003) experimentally induced feelings of social rejection in participants using a computer-based ball game paradigm, called Cyberball. In the game, participants play a game of virtual catch with two other players, but in reality, these two players are controlled by the computer. In the social inclusion condition, the computer-controlled players throw the ball to the participant; however in the exclusion condition, they leave the participant out and instead pass the ball between themselves. While simple, this paradigm has been shown to reliably elicit feelings of social rejection from the participants. By using functional magnetic resonance imaging (fMRI), Eisenberger and colleagues have demonstrated that there is a common neural pathway for physical and emotional pain and that those who are more sensitive to physical pain are also more sensitive to emotional pain and vice versa (Eisenberger & Lieberman, 2004; Eisenberger et al., 2006; Eisenberger, 2010.

Based upon this idea, it has been suggested that factors that increase or decrease one's threshold and tolerance for one type of pain, may also increase or decrease threshold and tolerance for the other, e.g. increasing tolerance for physical pain ought to increase tolerance for emotional pain (Eisenberger, 2010; DeWall et al, 2010). Following this, Ribeiro and Joiner (2009) suggest that repeated exposure to emotionally painful events may increase physical pain tolerance, thus also potentially increasing capability for suicide (Ribeiro & Joiner, 2009), a volitional phase variable. As men have a higher tolerance and threshold for physical pain, it may be posited that men may also have a higher tolerance and threshold for emotional pain. Men are reluctant to seek help, particularly for mental health issues (Branney & White, 2008), so a higher tolerance of emotional pain may lead men to wait longer before seeking support, if they seek it at all.

Empathy has also been linked to emotional pain sensitivity, with the same areas of the brain being active in participants when observing the social exclusion of a friend as when they experience social exclusion themselves (Meyer et al., 2012). A reduced

sensitivity to emotional pain may also then influence social problem-solving ability, with individuals who are less sensitive to pain being less able to put themselves in the position of others, potentially impeding their ability to generate effective means to solve social problems.

Capability

Van Orden et al. (2008) investigated the acquired capability for suicide, finding that it significantly predicted the number of past suicide attempts, with men demonstrating higher levels of acquired capability than women, although there were no differences according to age and the mean age of the sample (26.21 years) is outside of the target population.

Those who had attempted suicide scored more highly than the ideators on a self-report measure of acquired capability; however there were no significant differences in acquired capability found between healthy controls and either suicide ideators or those who had attempted suicide (Smith et al, 2010). Those in the attempt group also reported more painful and provocative events than either ideators or controls, which have been posited to increase capability by reducing sensitivity to pain (Ribeiro & Joiner, 2009). Gender was not included as a variable in the analysis.

In sum, there is a significant gap in the literature exploring volitional variables, with the majority of existing research being conducted on either young adult/undergraduate samples or adolescents.

Primary data analysis

Results

A dataset from a previous Chief Scientist Office funded study conducted by O'Connor et al. (2010) was analysed. The sample consisted of 550 adults (Mean age=34.5 years; SD=13.8) of which 227 were male. All had presented to the Accident and Emergency Department at the Royal Infirmary of Edinburgh, following an episode of self-harm. Participants completed a variety of measures, including the Beck Depression Inventory (BDI) (Beck et al., 1996), Beck Hopelessness Scale (BHS) (Beck et al., 1974), the Social Perfectionism subscale of the Multidimensional Perfectionism Scale (MPS-Social) (Hewitt & Flett, 1991), Means End Problem-Solving Task (MEPS) (Platt et al., 1975) and also gave demographic and clinical information relating to employment status, marital status, educational attainment, previous episodes of self-harm, psychiatric diagnoses and suicidal intent.

Analyses were conducted using SPSS 19 for Windows. As there were significantly more females than males in the sample and because males were the target group of interest, we have only analysed data from the male participants. The population of interest was those of low socio-economic status; this was operationalised as employment status. As a result, comparisons are between subgroups of males within the sample, for example, unemployed, versus in work/training, etc, not to females.

A one-way ANOVA revealed a significant difference in social perfectionism between those who were in employment and those who were not, $F(1, 225)= 8.48$, $p=0.004$, with males who were unemployed or not in training demonstrating significantly higher social perfectionism scores (M=64.77, 95% CI: 62-87-66.68) compared to those who were in work or training (M=59.94, 95% CI: 57.12-62.76). A significant difference in the effectiveness of solutions generated in response to social problem-solving tasks was also found between those who were employed and those who were out of work, $F(1, 225)=6.16$, $p=0.014$, with males who were unemployed/not in training exhibiting significantly lower solution effectiveness ratings (M=13.69, 95% CI: 12.92-14.46) compared to those in work/training (M=15.35, 95% CI: 14.21-16.51). Further analysis demonstrated a marginally non-significant trend for males who were not in work or training to feel more hopeless (M= 12.03 vs. 10.54, $p=0.051$) and more depressed (M=35.93 vs. 32.21, $p=0.056$) than those who were in education or employment.

Binary logistic regression was conducted to investigate the relationship between employment status and presence of a psychiatric diagnosis. The results showed that there was a significant association between employment status and

psychiatric diagnosis, with unemployed males who reported suicidal intent being 1.7 times more likely to have a psychiatric diagnosis than those who were in employment or training (p=.027, 95% CI: 1.02-1.36).This association was also found to be independent of the number of previous episodes of self-harm.

Focusing on those men who reported suicidal intent, more were single, separated, divorced or widowed than married or with a partner (n=133 compared to n=35). Additionally, the most common level of highest educational attainment amongst suicidal males was Standard Grade/O-level, followed by Highers/A-level.

Discussion

The results from the Scottish dataset showed that men who were unemployed scored significantly higher on measures of social perfectionism, in addition to generating less effective solutions to social problems than those not unemployed. While it has been previously reported that there is no correlation between perfectionism and social problem-solving ability (O'Connor et al., 2010) perceiving that others constantly expect one to be perfect when one has an impaired ability to solve social problems may potentially heighten psychological distress – and suicidal risk. Suicidal males were also more often single, divorced or widowed, than non-suicidal men. High levels of social perfectionism may result in relationship strain (Haring et al., 2003), and without the cognitive resources to solve these problems, this strain could potentially lead to separation or divorce.

Additionally, in the present sample, suicidal males had a lower level of educational attainment, compared to non-suicidal males. As certain indices of executive function, such as inhibition, have been found to be influenced by educational level, this may mean that the cognitive resources of suicidal males are further depleted, in addition to any deficits in social problem-solving ability that they may have. Of those who had endorsed suicidal intent, significantly more unemployed than employed men had a psychiatric diagnosis and this difference remained when controlling for number of previous self-harm episodes. Therefore it is less likely that incidence of psychiatric disorder was higher in this group as a result of more contact with the health services per se. The finding that likelihood of a psychiatric disorder was associated with employment is consonant with previous research, which found that presence of a psychiatric disorder was more common in manual than non-manual workers (Kosidou et al., 2011).

Although taken together these findings highlight a number of issues which may contribute to suicide risk in this population, the limitations of this dataset need to be considered. First, our findings only compare men who are unemployed to those who are in employment or in training. Future research ought to compare unemployed men with un-employed women directly before we can confidently say that these are mid-life male-specific risk factors. Second, these findings may not be generalisable to all mid-life men at risk; for example, they may not be applicable to those who die by suicide at a first attempt. Third, as we have not controlled for potential confounding variables, like area-level deprivation, it is not clear whether individual risk factors are more important than social factors.

Conclusion: Interpreting the findings within the IMV model

The current report has reviewed the extant psychological literature relating to suicidal behaviour in males of low socio-economic status, who are in mid-life; and presented the results of our own analyses of psychological factors in this population, using an existing dataset of men attending accident and emergency following an incident of self-harm. This section interprets the findings within the IMV model to suggest possible explanations for why men of low socio-economic position in mid-life may be at higher risk of death by suicide.

Pre-motivational phase

The IMV model (IMV) (O'Connor, 2011) suggests that the pre-motivational phase sets the context in which suicidal thoughts may develop. The stress of socio-economic deprivation appears to have a key role in

suicidal behaviour within this population (for example, O'Connor & Sheehy, 1997; Qin et al., 2000; Blakely et al., 2003), with males who are suicidal being significantly more likely to be unemployed or in low paid manual work (Mäki & Martikainen, 2007; Platt, 1984). Financial and housing issues are major areas of concern for men in this age range (for example, Matud, 2004; Windsor et al., 2008; Haw & Hawton, 2008). Psychological distress arising as a result of being unable to meet financial commitments (Yur'yev et al., 2012) or provide for dependents may be amplified by the increased stress response of men to achievement stressors (Stroud et al., 2002). Thus the interaction between males' predisposition towards an elevated response to achievement stressors, combined with stress from the environment such as financial worries, results in an increased likelihood of men of low socio-economic position experiencing suicidal ideation.

Our finding that the presence of a psychiatric disorder was more likely in unemployed males who were suicidal compared to those in work or training, is also consistent with the predictions of the IMV. Indeed, while this relationship is consistent with the general literature on the role of psychiatric illness within the suicidal process, (Haw et al., 2001; Witte et al., 2009), the evidence for any gender differences is mixed. Future research is required to investigate the extent to which this is a specific mid-life male risk factor for suicide.

The findings of the literature review are supported by the results of our own analyses, which found that unemployed males who had engaged in suicidal behaviour, scored significantly higher on social perfectionism – a pre-motivational variable – than those who were in work. Being highly socially perfectionistic leads one to feel as though one is constantly failing to meet others' perceived standards and acts as a predisposing factor for suicidality. In conjunction with chronic life stress, such as long-term unemployment, or the immediate stress resulting from sudden job loss, this becomes a significant risk factor for suicide.

Poor social problem solving and the passive-avoidant style of problem-solving exhibited by those who are suicidal (McAuliffe et al, 2002; 2006), could mean that what had previously been a trivial issue becomes elevated to the level of a major difficulty, as a result of putting it off, or waiting for it to remedy itself.

Motivational phase

The motivational phase variables of rumination, social problem-solving ability and future thinking were all found to be consistently associated with suicidal behaviour; however social problem-solving was the only one to demonstrate any differences as a function of age or gender. Unemployed men in our sample were also found to have a reduced ability to solve social problems, relative to males who were in work. Difficulties in solving social problems may result in challenges both at home and in the work place. This factor may increase the likelihood of having low levels of social support, resulting in feelings of entrapment progressing to suicidal ideation. The absence of social support (as indexed by marital status in our sample) is a key risk factor for suicide (Corcoran & Nagar, 2010; Haw & Hawton, 2011; O'Connor, 2003; O'Connor & Sheehy, 1997; Qin et al, 2000; Snowdon & Draper, 2011) and future research should endeavour to determine whether its effect on males is more pernicious in mid-life than at other times.

Volitional phase

Men's greater risk-seeking behaviour under stress (Lighthall et al., 2009; Van Den Bos, 2009) may create more life problems, and thus contribute to difficulties in the pre-motivational phase. Risk-taking may also be an important volitional phase variable, increasing men's likelihood of taking physical risks and using more lethal means.

The higher tolerance and threshold of men for physical pain (Braid & Cahusac, 2006; Gratz et al, 2011) may mean that men have a greater capability for fatal suicidal behaviour than women and allow them to use more lethal means. This volitional variable may also be linked to this population's reduced ability to solve problems; the common neural mechanisms for physical and emotional pain meaning that reduced sensitivity to physical pain

also reduces sensitivity to emotional pain, and therefore empathy. Capacity for pain could therefore be a key volitional moderator for this population.

Dearth of research

The reasons for suicidal behaviour are multifaceted and it is widely acknowledged that there is no one path to suicide (O'Connor & Sheehy, 2000). However from the perspective of psychological research, the potential routes to suicide for males in their middle-years remain "roads less travelled" and there is a distinct dearth of literature relating to this population. Those in middle age are a neglected population within psychological research and with little or no research within suicidology giving substantial focus to age or gender (as opposed to simply controlling for it); there are significant gaps in our knowledge, which must be addressed as an urgent priority.

The relationship between factors such as unemployment, relationship issues and social perfectionism is complex and while social perfectionism is thought to be a stable personality trait, further research is required to determine how it develops, including the role of early life adversity in its genesis. Future research should investigate the conjunction between biological and psychological factors and it should also make steps to identify whether there are biological bases for predisposing personality factors such as social perfectionism, or self-criticism.

As the ability to solve social problems is crucial, both at home and in the work place, and problems with social relationships are significant in the development of suicidality, particularly it seems for this population, further research which examines possible gender and age differences and the efficacy of interventions in this area, would be timely.

Implications for policy and practice

At the point of contact with psychiatric or other support services, more careful attention should be paid to individuals' life circumstances, particularly financial, employment or housing difficulties – and how these impact one's well-being. This may aid assessment of suicide risk in this population. The feasibility of education programmes for those who are unemployed or in financial difficulty should be explored, as this may increase men's feelings of control and thus reduce suicide risk. Indeed, the perception of control over life events, such as finances, has been shown to be associated with lower suicidality (Fairweather et al., 2006).

Given the importance of socially prescribed perfectionism and social problem-solving in the suicidal processes, interventions to target these processes in mid-life men should be developed.

More practical therapeutic interventions for this population ought to be explored, such as social problem-solving skills training. Hawton (2000) comments that the well-known tendency of males to be reluctant help-seekers may confound the efficacy of certain therapeutic interventions; in the first instance by help not being sought and in the second, by many interventions being 'talking therapies', which may not appeal to men, who are often disinclined to discuss their feelings. He suggests that interventions with a practical basis, such as those that aim to improve problem-solving skills, may be more successful with males. Consideration should be given to embedding social problem-solving within training programmes, to men's management of the expectations of others and to how men respond to stress.

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Men, suicide and society: an economic perspective

by Brendan Kennelly and Sheelah Connolly

Abstract

The aim of this review is to provide an overview of what economics can contribute to understanding suicide, focusing particularly on middle-aged men in low socio-economic positions. The main areas that are addressed are (1) economic theories which seek to explain individuals' motivation to die by suicide; (2) the empirical evidence on the socio-economic determinants of suicide; and (3) the economics of suicide prevention programmes. The report discusses some of the economic theories which have been developed to explain suicide behaviour. We find that these theories offer some insights into the role of economic factors, such as income or unemployment in understanding suicidal behaviour. Much of the contribution of economists to understanding suicide has come from empirical rather than theoretical work, and therefore the majority of this report focuses on the evidence on the economic determinants of suicide. The economic variables of interest include individual characteristics, such as employment status and indicators of socio-economic status (including income and education), as well as regional or national level indicators, such as the rate of economic growth, income inequality and the unemployment rate. While exceptions can be found, the balance of evidence suggests that, controlling for other risk factors, including the presence of psychiatric illnesses, being unemployed, having a low income, or living in a socio-economically deprived area increase one's risk of dying by suicide. In addition, most researchers have found that deaths by suicide tend to increase during recessions. The report goes on to consider the economics of suicide prevention and explores the potential of economics to help identify those who are in distress. The report concludes by considering the implications for suicide prevention policy and practice, with a particular emphasis on the practice of an organisation such as Samaritans.

Introduction

The aim of this review is to provide an overview of what economics can contribute to understanding suicide, focusing particularly on middle-aged men in low socio-economic positions. The areas that will be addressed are (1) economic theories which seek to explain individuals' motivation to die by suicide; (2) the empirical evidence on the socio-economic determinants of suicide; and (3) the economics of suicide prevention programmes. The report concludes by considering the implications for suicide prevention policy and practice.

The report begins by discussing some of the economic theories which have been developed to explain suicide behaviour. While economics may not be generally regarded as the most obvious discipline to develop theories of suicide, its contribution lies in the observation that suicide is an act and, at least in some sense, a choice; and economic theory is largely concerned with explaining choices.

Much of the contribution of economists to understanding suicide has come from empirical rather than theoretical work, and therefore the majority of the report will focus on the evidence on the economic determinants of suicide. The economic variables of interest will include individual characteristics, such as employment status and indicators of socio-economic status (including income and education), as well as regional-level

indicators, such as the level of economic growth, income inequality and the unemployment rate. We will draw on work from individual, national and cross-national studies and make particular reference to evidence for middle-aged men.

The report will then go on to address the economics of suicide prevention. Increasingly, economic evaluation is used to guide decisions about which health interventions should be funded. While the evidence on the cost-effectiveness of suicide prevention strategies is limited, the report will detail the available evidence, with particular attention to those programmes of most immediate interest to an organisation such as Samaritans. This section will also briefly address the potential of economics to explain why people with suicidal intentions may not seek help and to identify ways to encourage such people to seek help from the appropriate sources.

Finally, the report will conclude by considering the implications of the preceding discussion for policy and practice. Note that, for reasons of space, we only consider suicide and not non-fatal suicidal behaviour.

Economic theories on suicide

Hamermesh and Soss (1974) developed the Lifetime Utility Model in an attempt to explain suicide behaviour. Utility, in economics, generally refers to the total satisfaction or pleasure that a person receives from consuming a particular good or service. Economists generally assume a positive rate of time preference, so a larger premium is placed on utility nearer in time over utility further in the future. Therefore, future utility is usually discounted to make it comparable to utility in the current time period. The basic assumption of the Hamermesh and Soss model is that an individual chooses to die by suicide when the total value of remaining lifetime utility reaches zero (or when it falls below some threshold required to continue to live). Lifetime utility is determined by, among other variables, age, income and health. The theory suggests that suicide rates would increase with age (everything else held constant), since the cost of maintaining health increases with age. In addition, the theory predicts that income level has a negative effect on suicide rates because high income levels increase expected lifetime utility and decrease the 'benefit' of suicide.

The model, while not without its critics, is useful because its basic features illustrate what economics might be able to contribute to the understanding of suicide. In particular, the model assumes that people can weigh up the costs and benefits of staying alive as they might weigh up the costs and benefits of other decisions (this is not to say that all decisions are of the same degree of seriousness or consequence and should have the same time devoted to them). An underlying assumption of the cost-benefit approach is that people are rational; however, many suicide researchers, particularly psychiatrists, would challenge the assumption that the decision to complete suicide is always rational. One of the most widely cited statistics in suicide research is that between 90 and 95% of those who die by suicide, at least in Western countries, are suffering from some mental disorder (Cavanagh et al., 2003). How and whether this statistic can be reconciled with rational behaviour is a very difficult question and one that is beyond the scope of this report. We proceed on the basis that economics can help by exploring whether economic circumstances, such as income, employment and area deprivation affect the propensity of people both with and without mental disorders to consider suicide, while remaining open to the possibility that having a mental disorder is not necessarily incompatible with rational behaviour. Economic analysts of suicide generally accept that economic factors are not the only, or indeed the main, cause of suicide and some researchers have pointed out that regular fluctuation between suicide and economic conditions could be regarded as evidence that suicide is not solely due to irrational behaviour (Daly & Wilson, 2007).

The main criticism of the Hamermesh-Soss model is that a rational individual should take into account the possibility that life might improve. Given that suicide is an irreversible act, the 'option value' of staying alive could be extremely large (Dixit & Pindyck, 1994). A second problem is that the model is only concerned with the aggregate of lifetime utility and not with its timing; in other words, it does not take into account, for example, that in mid-life

there may be less likelihood that life will change or improve than when one is young. It simply states that a rational individual would not choose to die in the current period if her/his utility in that period was positive. One model, incorporating this option value on the potential of future life, no longer predicts any direct relationship between suicide and age because there is no clear prediction as to the time sequence of future utility (Cutler et al., 2001).

The Hamermesh-Soss model has also been extended to take account of other potential risk factors and socio-economic contexts. One important paper (Daly & Wilson, 2006) focuses on whether one's relative position matters as well as one's absolute position in assessing one's life. Standard economic theory generally assumed that a person's utility was positively correlated with her/his income and was unrelated to the income of other people. This approach has been strongly challenged in the past 30 years by both economists and psychologists, who have argued that a person's utility is also determined by their relative income. For example, if everybody's income rises by the same percentage, a person's utility will not change much, if at all, because relative income has not changed. However, a person's utility may fall if his/her income increases at a rate less than the average increase in income. The relative income hypothesis may be especially pertinent for thinking about how either a rapid economic expansion or a deep recession affects particular individuals as neither phenomenon will affect all individuals in a country uniformly. It is also consistent with Durkheim's contention that economic crises, including rapid upturns as well as downturns, are associated with greater suicide risk (Durkheim, 1897).

The Hamermesh-Soss model has also been used to explain specific empirical phenomena, such as the rise in suicide among middle-aged men in Japan in the 1990s (Koo & Cox, 2006). Their model hypothesises that any individual's human capital (i.e. their set of skills and capabilities) declines as a result of unemployment (because of, for example, the loss of on-the-job training). During periods of sustained economic transition driven by technological shocks, the human capital of middle-aged unemployed people depreciates faster than that of younger workers because they tend to be slower in adapting to new labour market conditions. This in turn (along with other factors such as a greater chance of divorce) drives down the expected relative lifetime utility of unemployed individuals and thus increases the risk of suicide.

One aspect of the economic approach that has not received as much attention is the way in which decreased utility or distress is produced and managed. Lillard and Firestine (2006) examine how a person chooses to manage such distress, using what economists call 'a production function' approach. This assumes that an output such as emotional wellbeing that an individual experiences is dependent on certain chosen inputs. These inputs might either be health-related goods (such as drugs and counselling) or non-market activities (relationships with friends and family). When an individual experiences a negative event, such as the onset of depression, that substantially reduces his/her emotional wellbeing, the optimal mix of inputs in the production of emotional wellbeing needs to change. Their model predicts that a reduction in the availability of antidepressants (for instance as a result of an increase in price or a reduction in one's income) should cause individuals to spend more time cultivating relationships with friends and family to bolster mental wellbeing. This model, and most other economic models of suicide, ignores the possibility that mental illnesses in themselves make it more difficult for a person to respond rationally to a mental illness. For example, many of the actions recommended for people who are depressed – do more exercise and participate more in community activities for example – are harder to do when a person is depressed.

More realistic models of human behaviour that may help us understand suicidal behaviour have been developed in the past twenty years and these are generally captured by the term behavioural economics theories. An important aspect of behavioural economics is that it does not presume that all choices are rationally made or that a person will always choose the outcome that is best for her/him. Behavioural economics focuses on the process of decision-making as much as the outcome itself and is more closely linked to psychological theories of choice and behaviours. We expect and

hope that more theoretical insights into suicide will be obtained from behavioural economics theory in the near future. For example, theories of procrastination may provide insight into why some people who are suicidal do not seek help.

Economics and suicide: the evidence

Most of the contribution of economists to understanding suicide has come from empirical rather than theoretical work, and therefore the majority of this report will focus on the empirical evidence. The economic variables of interest will include individual characteristics such as employment status and indicators of socio-economic status (including income, education and social class), as well as regional-level indicators such as per-capita income, income inequality and the unemployment rate. We will draw on work from individual, national and cross-national studies and make particular reference, where available, to evidence for middle-aged men. Our literature search methodology included systematic searches for relevant key words on various databases and search engines. We also used recent reviews of economics literature by Chen et al. (2012) and by McDaid and Kennelly (2009) as well as the literature review sections in other recently published papers.

Employment status

Currently, the United Kingdom (UK) and Ireland (along with many other countries) are experiencing a significant economic crisis. For many, the most salient feature of this crisis is the growth of unemployment. There has been a dramatic increase

Box 1

There are essentially four types of study designs that have been used to explore the relationship between economic variables and suicide: (1) Cross-country studies focus on country level variables such as the unemployment rate and economic growth, and analyse how these are related to country level suicide rates. These studies can either use data from a single year (in which case they are known as a cross-sectional study) or a number of years (panel data studies). These types of studies have mainly used data from high- and middle-income countries because of problems with the availability of reliable data. (2) Regional studies are similar to cross-country studies except that the unit of analysis is a region of a particular country such as a state or a county. (3) The third type of study is individual country studies. These involve an analysis of how suicide and socio-economic data have varied over time, with a year being the typical unit of time involved. (4) Finally, there are individual-level studies where the characteristics of those dying from suicide are examined.

The first three types of studies indicated above employ an ecological study design in which the unit of analysis is a population rather than an individual. All ecological studies are potentially prone to the 'ecological fallacy', which is that an association that exists at an aggregate level may not represent the association that exists at an individual level. For example, finding an association between the unemployment and suicide rate across countries or over time does not necessarily imply that unemployed individuals are more likely to die by suicide. To address such questions, individual level studies – such as those included under study design (4) – are required.

Another issue that should be borne in mind is that the majority of empirical studies focus on explaining the overall suicide rate or the overall male and female suicide rate. Those studies that try to explain age- and gender-specific suicide rates face an important data problem in that many of the outcomes variables are not available on a gender- and/or age-specific basis.

in unemployment in Ireland for the population as a whole (from 4.6% in 2007 to 14.4% in 2011) and for men in particular (from 4.9% to 17.5%). Female unemployment in Ireland increased from 4.1% to 10.6% during the same period. Overall unemployment in the UK increased from 5.3% to 8% between 2007 and 2011, with a slightly higher increase in the rate for males (5.6% to 8.7%) than for females (5.0% to 7.3%). (All data are taken from the Eurostat database).

In reviewing the relationship between employment status and suicide, the report begins by reporting on cross-country studies which examine the association between the unemployment rate and suicide rate for particular countries, and then goes on to examine regional and country-specific studies, before looking at risk of suicide among the population that is unemployed at any point in time. A later sub-section will focus on the impact of recession on suicide rates.

Cross-country studies

A number of cross-country studies report a positive and statistically important association between unemployment and suicide after controlling for other relevant variables, with higher unemployment rates associated with higher suicide rates (Lin, 2006; Neumayer 2003; Milner et al., 2012). Yamamura and Andrés (2011) found that unemployment had a weak positive effect on the overall suicide rate in a panel study of 24 OECD countries covering the period 1995 to 1999. When the analysis was conducted separately for men and women, the significant effect was only present for females. Other cross-country studies have found no significant effect of unemployment on suicide (Chen et al., 2009; Helliwell, 2004; Gerdtham & Ruhm, 2006; Andrés, 2005), although Andrés (2005) noted that unemployment rates were positively (but not significantly) associated with suicide rates for males aged 25 to 44. Barth et al., (2011) found that unemployment had no effect on male suicide rates, but had a positive effect on female suicide rates in a panel study of 18 countries covering the period 1983 to 2007.

There is an absence of age group analysis in regional studies (which examine how the suicide rate in a state or county is affected by socio-economic variables in the region concerned). Dahlberg and Lundin (2005) found a positive relationship between unemployment and suicide for both men and women using county level data from Sweden. Minoiu and Andrés (2008) analysed data for the US states between 1982 and 1997 and found that unemployment had no effect on overall or male suicide rates, but in some specifications it was found to be positively and significantly associated with female suicide rates. Similar results for the overall suicide rate were found in an earlier study of US states by Kunce and Anderson (2002): the unemployment rate was not significant in their preferred model.

Platt et al. (1992) found that among men, the unemployment rate was positively correlated over time with the suicide rate, but that the change in the unemployment rate across 18 geographic regions of Italy was unrelated to the change in the suicide rate. Conversely, cross-sectional analyses showed a negative relationship between the regional unemployment rate and the regional suicide rate. The authors concluded that “on the basis of this contradictory and inconsistent evidence, we are cautious about offering definitive interpretations concerning the nature of the unemployment and suicide link among men” (Platt et al., 1992, p.1191).

Single country studies

Several single country studies have examined the relationship between unemployment and suicide and some of these have focused on particular demographic groups.

Walsh and Walsh (2011) examined the association between age- and gender-specific unemployment and suicide in Ireland between 1988 and 2009. They found that unemployment over this period was positively and statistically significantly associated with suicide. The effect was particularly strong and significant for males aged between 25 and 34, positive but weakly significant for the 35–44 male age group, and not statistically significant for the 45–54 age group. The results were much weaker for

females. (Note that the unemployment rates used in this paper was the unemployment rate of the particular gender and age group in question.)

In a follow-up paper, Walsh (2011) noted that there was a large fall in the suicide rate in Ireland in 2010, especially among males aged 25 to 34 and 35 to 44, and thus the negative association between unemployment and suicide is not robust. Re-running the same estimations as Walsh and Walsh (2011) with the addition of 2010 data, he found that the effects of unemployment on suicide were not as strong. For example, unemployment was now only significant in the analysis on males aged 25–34 and the coefficient on the unemployment rate was much lower than the analysis covering the 1988 to 2009 period.

Ceccherini-Nelli and Priebe (2011) examined the associations over time between economic factors (including unemployment) and suicide in the UK, US, France and Italy. They found that, in all four countries, increases in unemployment were linked with higher suicide rates and decreases of unemployment with lower suicide rates. The effect of unemployment on suicide in the UK was similar for males and females.

Andrés and Halicioglu (2010) found that unemployment was positively associated with both male and female suicide rates in Denmark in a study covering the period 1970 to 2006 and that the size of this effect was very similar for both genders. Biddle et al. (2008) showed that the decline in suicide rates among young men in England and Wales during the 1990s and early 2000s was paralleled by a decline in the unemployment rate.

Individual-level studies

The next types of studies reviewed are individual-level studies where the focus of analysis is on the individuals who have died by suicide. These studies can be based on administrative data or data collected in psychological autopsy studies.

We begin with studies based on **administrative data**. Corcoran and Arensman (2011) calculated annual age-specific suicide rates (including deaths recorded as suicide and undetermined intent) for those aged 15–34, 35–54 and 55 plus for both men and women in Ireland. Two time periods were examined – 1996 to 2000 when unemployment was falling rapidly, and 2001 to 2006 when unemployment was low and stable. They found that the suicide rate was higher among the unemployed than the employed for both men and women. The difference in suicide risk between employed and unemployed males was higher in the second period, increasing from a two-fold difference to a three-fold difference. The increase in risk for men from being unemployed was highest for those aged between 35 and 54. Unemployment was a stronger risk factor for suicide among women than among men and the risk associated with being unemployed was highest among older women. In the UK, Lewis and Sloggett (1998) found that those who were unemployed were two and a half times more likely to die by suicide than the employed in England and Wales.

In the United States, Kposowa (2001) followed a cohort of five national samples from the National Longitudinal Mortality Study (NLMS) between 1979 and 1989 to address the issue of whether unemployed individuals are at greater risk for suicide than the employed, while controlling for confounders. The results suggest that an unemployed person is at greater risk of suicide but found that the effect diminished with time. After two years of follow up, unemployed men were over twice as likely to die by suicide as their employed counterparts but there was no statistically significant difference in the relative suicide risk after four years of follow up. Unemployment increased suicide risk in women as well as men. Similar results have been found in recent studies of large data sets in Finland and Sweden (Maki & Martikainen, 2012; Lundin et al., 2012). Several studies have used comprehensive registry data on suicide in Denmark to look at the association between individual level socio-economic indicators and suicide. Andrés et al. (2010) identified over 15,000 individuals aged between 18 and 65 who died by suicide in Denmark between 1981 and 1997. The found that being unemployed was associated with a higher risk of suicide. This risk was reduced but not eliminated when controlling for psychiatric admission history.

Finally in this section we refer to **psychological autopsy** studies which are based on information collected from people who knew the suicide decedent before the person died. The typical study compares suicide decedents to a control group of people who have died from another cause or to a randomly chosen group of people who are alive. A meta-analysis by Yoshimasu et al. (2008) included 16 psychological autopsy studies that had examined the role of employment status as a risk factor for suicide. They found overall that the risk of suicide was two to three times higher for people who were unemployed compared to people who were employed. This result includes both men and women of all ages. The results for men were not statistically significant due to the small number of studies. Their analysis included data from four studies in the UK (Appleby et al., 1999; Foster et al., 1999; Houston et al., 2001; Owens et al., 2003). The odds ratio associated with being unemployed in these studies ranged from 1.00 in Houston et al. (2001) to over 4 in Appleby et al. (1999).

Schneider et al. (2011) found a very large effect of unemployment in a study on suicide in the Frankfurt/Main area. People who were unemployed were more than 16 times more likely to die by suicide than people in the control group. This risk was not substantially altered after adjusting for mental illness and personality disorder.

Summary of evidence on unemployment

Overall, then, it seems that higher levels of unemployment are associated with higher rates of suicide. While some studies have found the effect of unemployment on suicide risk to be greater among females, others have found little or no gender differences. Stuckler et al. (2009), for example, found no evidence that men and women were differently affected in relation to suicide by rising unemployment The relatively few studies which have incorporated different age groups tend to show a stronger impact of unemployment on younger (those in their 20s and 30s) people's risk of suicide.

Among individuals, being unemployed is a significant risk factor for suicide. This may be due to a direct effect – being unemployed increases suicide risk – or it may capture an indirect effect where unemployment increases the risk of mental ill-health which in turn increases the risk of suicide. In addition, people with psychiatric illness are more likely to be unemployed, which makes it difficult to identify the true causal factor in suicide risk. For example, Lundin et al. (2010) estimated that at least two thirds of the increased relative risk of suicide associated with becoming unemployed in a Swedish study could be attributed to a higher prevalence of mental illness or risk factors for mental illness in people who were unemployed.

Income

Cross-country studies

Several cross-country studies have examined the association between per-capita income and suicide, with mixed results. Some have shown that a higher GDP per capita is associated with a lower suicide rate, after controlling for a range of other socio-economic variables (Neumayer 2003; Chen et al., 2008; Helliwell, 2004). Milner et al. (2011) in their analysis of 35 high and middle income countries over the period 1980–2006 found that GDP per capita was associated with a significant reduction in male suicide rates but not female suicide rates. Similarly, Chen et al. (2008) found that real GDP per capita had a significant negative effect on suicide rates for males but not for females in a study of OECD countries. They also found that per capita income had a significant negative effect for males aged 45 to 64 but the effect was not significant for other age groups among men. Using data from 15 European countries, Andrés (2005) found that GDP per capita was negatively associated with suicide in males aged 25 to 44 and 45 to 64 but these results were not statistically significant.

On the other hand, some studies have found that higher income levels are associated with a higher suicide rate. For example, Jungeilges and Kirchgässner (2002) found the higher the real per capita income, the higher the suicide rate, with income having its strongest impact for age groups between 35 and 64 years. Neumayer (2003) found that income had a non-linear effect on suicide rates.

Both of these studies included high- and middle-income countries as well as a small number of low-income countries. Higher income levels first lowered the suicide rate, but at a decreasing rate and then raised the suicide rate after a certain income level had been reached, with the turning point estimated to be around US$30,700. Barth et al. (2011) analysed a panel data set covering 18 high-income countries and found a positive relationship between per capita GDP and the female suicide rate but a negative relationship between the same variable and the male suicide rate.

Dahlberg and Lundin (2005) found no relationship between per-capita net income and suicide for either men or women using county level data from Sweden. In the US, Minoiu and Andrés (2008) found that state income had no effect on overall, male or female, suicide rates. Similar results were found in the earlier study by Kunce and Anderson (2002) - the median state household income was not significant in their preferred model.

Single country studies

Several single country studies have examined the association between income and suicide. Andrés and Halicioglu (2010), for example, examined the determinants of suicide in Denmark over the period 1970 to 2006. They found a negative relationship between income and suicide and estimated that each 1% increase in per capita real income would decrease the number of male suicides by 1.73%. For Ireland, Lucey et al. (2005) assessed the association between change in a range of socio-economic indicators and changing total, male and female rates of suicide during the period 1968 to 2000. They found no association between GDP and suicide. Ceccherini-Nelli and Priebe (2011) found no association between GDP per capita and male or female suicide rates in the UK.

Individual level studies

All of the aforementioned studies use the average economic characteristics of particular countries; therefore they were unable to explore a causal link between individuals' economic situations and their decision to die by suicide (Chen et al., 2012). More insight into this question can be gleaned from a few studies that have detailed socio-economic data on the individuals who died by suicide. In the US, Daly et al. (2010) used individual-level data on suicide to investigate whether individuals consider their relative economic position as well as their absolute economic situation in assessing their utility. Using predicted income, their results suggested that suicide risk falls as the individual's own income rises. They also showed that, holding own income constant, suicide risk rises as county income rises. In a related analysis of an alternative dataset they found that own income had a significant negative effect on suicide risk only for people with low income. The results also showed that county income had a positive effect on suicide risk holding other factors constant, which again suggests that relative as well as absolute income matters.

Denmark et al. (2010) found a U-shaped association between income and suicide risk, with the risk being highest in the lowest income quartile and lowest in the middle-income groups. The elevated risk associated with low income was particularly marked for men. Qin et al. (2003) found that men in the lowest income quartile were more than three times more likely to die by suicide compared to men in the highest income quartile even after controlling for a range of other factors, including employment status and psychiatric admission history. Agerbo et al. (2007) examined socio-economic risk factors for suicide in Denmark among men and women aged 25 to 60, sub-divided by age group. They found that suicide risk increased with declining (individual) income levels. These associations were stronger in males than females and among younger compared to older subjects. For example, males aged 25 to 40 in the lowest income quartile had a suicide risk more than five times that of those in the highest income quartile, while in men aged 41 to 60 years the excess risk was less than three.

Occupational status

Several studies in the UK have looked at suicide rates by social class. For example, Drever et al. (1997) examined cause-specific male mortality for ages 20 to 64 between 1991 and 1993 in England and Wales. They showed that there was a four-fold difference in the standardised suicide mortality ratio (SMR) of

suicide between those in professional and unskilled social class. The SMR was 55 for the professional class compared to 215 for the unskilled. Kreitman et al. (1991) looked at suicide and undetermined deaths by age, economic activity status and social class in males of working age in England and Wales. They found no clear gradient among social classes I, II, III Non-Manual, III Manual, an increase in social class IV and a further considerable rise in social class V. For men aged 35 to 44, the mortality ratio was 0.76 in social class I compared to 2.73 in social class V; for men aged 45 to 54, the mortality ratio was 1.26 in social class I and 2.00 in social class V. The gradients for mortality due to undetermined intent were steeper. They also found a significant interaction between age and social class, with particularly high suicide rates among those aged 25 to 44 in social class V. Kreitman et al. (1991) concluded that there was a concentration of suicide and undetermined deaths in the middle age groups of the lower social classes. Plausible explanations include both the social drift hypothesis (where, for example, chronic mental illness, including alcohol dependency, leads to deterioration in social position) and unemployment.

Uren et al. (2001) examined deaths among men aged 20 to 64 for 1991–93 in England, Wales, Scotland and Northern Ireland separately. For suicide, there was a clear social gradient, with a four-fold difference in mortality between social classes I and V for the UK as a whole. This was mainly associated with excess mortality in social class V. The gradient was less apparent when this social class was excluded. Platt (2011) examined the association between social class, socio-economic deprivation and suicide in Scotland over the period 1989 to 2002. He found that lower socio-economic status was a risk-factor for suicide. There was evidence of both a step-change in risk between non-manual and manual social classes and a gradient between non-manual social classes and each successively lower manual social class.

Other indicators of socio-economic status

Other variables have been used to assess the relationship between socio-economic status and suicide, including education, housing tenure and car access. Lorant et al. (2005) examined socio-economic inequalities in suicide among men and women in 10 European populations. For all male populations the suicide mortality rate was higher in the group with a lower educational level. This result was especially marked in England and Wales where men with the lowest level of education had more than two and a half times the risk of those with the highest level of education. Lewis and Sloggett (1998) investigated the association between suicide and socio-economic status, unemployment and chronic illness in England and Wales using individual level data from the Office for National Statistics Longitudinal Study. They found no significant association between social class and educational attainment with suicide risk after controlling for other variables (including age, sex, marital status and economic activity). However, car access (an indicator of socio-economic position) remained statistically associated with suicide risk.

Area effects on suicide

The relationship between the level of inequality and other measures of income distribution and suicide rates in developed nations has also been considered. Again, the evidence is mixed. In cross-country studies some researchers have found a positive relationship between income inequality and suicide (Chen et al., 2008), while others fail to find a statistically significant relationship (Leigh & Jencks, 2007; Andrés, 2005; Andrés, 2006).

Several studies have examined the association between area-based socio-economic variables and area suicide rates (McLoone, 1996; Congdon, 2004; Rezaeian et al., 2007). Area-based socio-economic variables have included the unemployment rate, income, deprivation indicators and the proportion of manual workers. In general, the results of these studies have been mixed. Some analyses have found a positive association between area-based socio-

economic variables and male suicide risk (McLoone, 1996; Rezaeian et al., 2005; Rezaeian et al., 2007), with more disadvantaged areas having higher suicide rates. Rezaeian et al. (2005), for example, found a strong association between suicide rates and indices of deprivation in English local authorities for middle aged males (30–49), but not for females or older people; Razaeian et al. (2007) noted that the hot spots index of deprivation in London predicted the rates of suicide in males 30–49 better than in other age and sex groups

However, a review by Rehkopf and Buka (2006) of 221 analyses reported in 86 papers of the association between suicide and socio-economic characteristics of geographical areas found that 55% of analyses found no significant association between the socio-economic characteristics of a region and suicide, 32% reported a significant negative relationship (areas of lower socio-economic position tended to have higher suicide incidence) and 14% found a significant and positive relationship. The strength of the association varied according to the size of the geographical unit under consideration: studies based on smaller geographical units were significantly more likely to report higher rates of suicide in lower socio-economic areas than studies based on larger geographical units. The authors identify a number of potential reasons for this, including a more homogenous population at the small area level and the possibility that contextual factors (such as social networks) related to suicide risk operate at small, but not larger, levels of aggregation.

As previously indicated, there are several problems with studies using an ecological design, not least of which is that while more socio-economically deprived areas may have higher suicide rates, the people who die by suicide may not actually be socio-economically deprived themselves. In addition, area deprivation may be correlated with other area-based indicators which influence the risk of suicide. For example, Middleton et al. (2004) found that the strong association between suicide and unemployment in 15 to 44 year old males was attenuated after controlling for the effect of other area characteristics, including social fragmentation and population density. Conversely, however, Whitley et al. (1999) found that the association between suicide and area deprivation in 15 to 44 year old males remained even after controlling for area-based social fragmentation .[1]

It is arguably more important to determine whether effects found at the area level are due to the characteristics of the people living in these areas (composition) or to an effect of the area itself (context). O'Reilly et al. (2008) found that the higher rates of suicide in the more deprived and socially fragmented areas in Northern Ireland disappeared after adjustment for individual and household factors. Using the Danish data previously mentioned, Agerbo et al. (2007) found that the association between area-level characteristics (including employment and income) and suicide risk among men aged 25 to 40 were greatly reduced after controlling for the characteristics of the individuals living within the areas. On the other hand, Martikainen et al. (2004) found that the significant association between area variables (proportion of manual workers and unemployment level) and suicide for males aged 15 to 64, while attenuated by the inclusion of individual-level characteristics, did not completely disappear. They suggested that the socio-economic structure of an area may affect suicide through behavioural cultures and psychosocial mechanisms. Those living in areas with a high level of unemployment possibly experience more hopelessness and loss of self-efficacy than people in better-off areas, and this despair may be reflected in the suicidal behaviour and excess alcohol use of some of the residents in these areas. Platt (2011) found that suicide risk increases with increasing levels of area deprivation. However, the influence of individual social class was found to be far stronger than the area effect.

The impact of recessions on suicide

Much of the empirical work on suicide has looked for associations between suicide rates and macroeconomic variables over time (see box 1). For the most part that work has treated each year of data in the same way and has not distinguished periods of normal economic activity from periods of rapid economic change. A somewhat different approach has also been explored. Several studies

have examined how mortality – both all-cause and cause-specific mortality – changes during economic expansions and economic contractions. It might be expected that mortality in general would increase during a recession and decline during an economic expansion. However, in recent years, many authors have found a somewhat surprising result – namely that overall mortality tends to decline during periods of recession (Ruhm, 2000; Gerdtham & Ruhm, 2006). Ruhm (2000) identifies a number of reasons why overall health may improve during a recession, including an increasing amount of leisure time which may be used for health-enhancing activities such as exercise, as well as lower motor traffic and work-related accidents. Within the overall trend of declining mortality, however, some researchers (e.g. Ruhm, 2000) have found that suicide is an exception to the general rule, i.e. that deaths by suicide increase during recessions, although others have argued that this finding is not robust (Ionided et al., 2011). In explaining this phenomenon, Ruhm (2000) raises the possibility that worsening economic conditions may have negative effects on some facets of mental health, while improving physical wellbeing. Several media reports have linked the current recession to increases in suicide in the UK, Ireland and other countries.

Given the current economic recession and the rapid increase in unemployment experienced in the UK and Ireland (especially among men), what is the likely impact on suicide? Stuckler et al. (2009) examined the impact of unemployment on suicide rates in 26 EU countries between 1970 and 2007. They found that every 1% increase in unemployment was associated with a 0.79% rise in suicides at ages younger than 65 years. Large increases in unemployment (defined as increases of more than 3% in a year) were associated with even larger increases in suicide (about 4.5%). The effect of unemployment was positive but insignificant for men aged between 45 and 59 and positive and significant for men aged between 30 and 44. In a follow up study Stuckler et al. (2011) found that, out of 10 European Union countries examined, nine had higher suicide rates in 2009 than in 2007.

Garcy and Vågerö (2012), examining the relationship between the length of unemployment during the Swedish recession of 1992 to 1996 and mortality in the following six years, found that the risk of suicide among men increased with the length of unemployment. In the US, Classen and Dunn (2012) analysed variation in monthly suicide and unemployment data in a panel of US states between 1996 and 2005. They found that an increase in the number of individuals who are unemployed less than 5 weeks was not associated with the number of suicides. In contrast, an increase in the number of people who are unemployed between 15 and 26 weeks was associated with an increase in suicides. They also found some evidence that mass lay-offs (defined as more than 50 people being made redundant by the same employer in a particular month) increased the suicide risk among men in the short-term. Looking at gender-specific effects, they found that an increase in the number of job losses from mass-lay offs was positively associated with suicide for both males and females. They estimated that one additional suicide death per month would occur for every 4200 males who lost their job as part of mass-lay offs; for females, they estimated one additional suicide for every 7100 mass lay-offs. Browning and Heinesen (2012), using administrative data relating to all persons in Denmark, found that job loss increased the risk of overall mortality and suicide. The effect on suicide of job loss was very strong in the first three years but insignificant in the long term.

Some country-specific studies have found little or no effect of economic recession on suicide. Neumayer (2004) analysed the effect of state unemployment and economic growth on mortality in Germany between 1980 and 2000 and found that unemployment was negatively and significantly associated with suicide. As noted earlier, a recent Irish study found that, despite a significant increase in unemployment in Ireland, the suicide rate actually fell in 2010 and the fall was particularly pronounced in younger males (Walsh, 2011). (Subsequent years of data are required to determine whether 2010 was an unusual year.) Thomas and Gunnell (2010) observed large increases in suicide rates during the Great Depression of the 1930 in England and Wales. However, Gunnell et al. (2009) note that

improvement in welfare support and other changes since the 1930s may offset the impact of economic recession on suicide.

The contrasting results may be explained by the welfare policies introduced within particular countries to deal with the potential adverse mental health effects of economic crises. Stuckler et al. (2009), for example, found that, for every US$10 higher investment in active labour market programmes, there was a 0.038% lower effect of a 1% rise in unemployment on suicide rates in people aged less than 65 years. When this spending was greater than US$190 per head per year, a 3% rise in unemployment was estimated to have no significant adverse effect on suicide rates.

Economic evaluation of suicide prevention programmes

Over the past twenty years health economists in Ireland and especially in the UK have played an increasingly important role in advising health authorities how to allocate scarce resources. The basic idea behind health economic evaluation is that, since the budget available to publicly funded health systems is limited, decision-makers should allocate the available resources in order to produce the greatest possible benefit to the community. Cost effectiveness or cost utility analysis operates by comparing the gain in health to the increase in costs of an intervention and recommends that, for given improvements in health, low cost interventions should be funded before more expensive interventions. A health intervention could refer to anything from a medical procedure or drug to a psychological therapy to a public information campaign.

In principle the same kind of thinking could be applied to suicide prevention interventions. One could set up a random controlled trial whereby one group of suicidal people were given treatment as usual while another were given some additional intervention (a new drug or additional therapy etc) and the outcomes could be monitored for a period of time to see whether the intervention group had a lower suicide rate than the control group. In practice this rarely happens because mental health care professionals are very reluctant to withhold treatment that they think might be effective from people that they consider to be a high risk of suicide. There are very few studies that directly study how to reduce suicidal behaviour. Indeed, Dr. Maria Uquendo, a leading suicide researcher in the US was recently quoted as saying “we essentially have next to no good information about what the most reliable treatments are to prevent suicidal behaviour” (Dolgin, 2012: 190).

We are left with a small number of studies that have looked at the costs and benefits of interventions that might reduce suicide. However, these studies are not clinically or experimentally based, as would often be the case with other health interventions. One rare example of the evaluation of an area-based prevention strategy, albeit with many limitations and highly context-specific, is a retrospective analysis of a suicide prevention programme targeted at members of a reservation-based Native American tribe in New Mexico (Zaloshnja et al., 2003). The intervention focused primarily on young people aged 15–19, with the whole community as a secondary target group. It included peer training of young people, postvention outreach, community education programmes, and suicide-risk screening within local health and social care programmes. The rate of suicidal acts and suicides in the eight years prior to the programme was compared with suicides over the subsequent eight years. Direct and indirect costs were estimated. Overall the programme was deemed to have cost savings of US$1.7 million due to the marked decrease in the rate of suicide from 59 per 1,000 population in the 15–19 age group to a much lower rate (varying between 10 and 17 per 1,000) in subsequent years. Benefits gained were 43 times greater than costs incurred, while the cost per quality adjusted life year saved was just US$419, a value that is considered to be highly cost effective in most jurisdictions. These findings must, however, be treated cautiously, not least because of the lack of a comparator group and observed natural cyclical changes in suicide rates within this population group.

Another study estimated the potential cost effectiveness of a general suicide education and peer support group programme targeted at university students in Florida (De Castro et al., 2004). The study indicated that, because of the substantial lifetime costs avoided, both programmes would be highly cost saving, with the peer support programme and the general education programme generating benefits 5.35 and 2.92 times respectively greater than costs.

While the socio-economic analysis of suicide has explored a great deal of interesting data, it is important to acknowledge that whatever we learn about risk factors at an individual level, and whatever coefficients turn out to be statistically significant in ever more sophisticated econometric papers, this is of limited value to the critical issue of identifying which particular individuals in relatively high risk groups are especially likely to consider suicide. This issue is not confined to socio-economic analysis; it is also an issue for medical studies. A recent study in the US looked at 381 people who died by suicide and who had had at least one medical consultation with the Veterans Administration medical service in the last year of their life (Britton et al., 2012). Of the sample, 261 were noted in their charts as having reached a diagnostic threshold for some psychiatric illness. Only 91 of the 261, however, were found to exhibit suicidal ideation and only 47 of them had a suicide plan. Thus, overall, only 13% of a group of people who died by suicide indicated that they had a suicide plan in a consultation that took place within a year of their death.

It remains the case that successful suicide prevention will continue to be heavily dependent on people who are suicidal signalling to others that they are considering suicide. We know very little about why suicidal people do not make greater attempts to seek help. We think more research should be focused on this issue and that it is possible that economic theories of signalling and behavioural economics might have something to contribute to this research.

Conclusion: implications for policy and practice

The evidence we summarised in the main section of this report shows that people on low income and people who are unemployed are at a higher than average risk of suicide. While exceptions can be found in some studies, the balance of the empirical evidence is that, controlling for other risk factors such as the presence of psychiatric illnesses, being unemployed, having low income, or living in a socio-economically deprived area increase the risk of dying by suicide. In addition, most researchers have found that deaths by suicide tend to increase during economic recessions. While some studies have found the effect of unemployment on suicide risk to be greater among females, others have found little or no gender differences. The relatively few studies which have incorporated different age groups tend to show a stronger impact of unemployment on risk of suicide among younger adults.

A key difficulty facing suicide prevention practitioners is the difference between the number of people who say that they have seriously thought about suicide and the much smaller number who actually die by suicide. For example, a recent report in Ireland, published by the Headstrong Foundation, found that one third of young adults aged between 17 and 25 reported that they had thought that life was not worth living at some point within the last year. Even in socio-economic or demographic groups with a higher relative risk of suicide, the number of people who will choose to die by suicide is very small compared to the size of the group. Walsh and Walsh (2011) estimated that in Ireland the annual suicide rate in a group with a relatively high suicide risk such as young unemployed males, is likely to be no higher than 1 in 800. Effective suicide prevention efforts must rely heavily on people who are suicidal identifying themselves as being so. Organisations such as Samaritans are in principle able to reduce this identification problem because people who contact them are signalling that they are in a crisis and many of Samaritans' contacts are with people who reveal that they are thinking about suicide. But if we added together all the people who contact a crisis intervention service in a particular year the

number would be very large relative to the number who would die by suicide in the same year.

The last topic that we want to explore in this section is what an organisation such as Samaritans can learn from research on the relationship between suicide and economic factors. The first issue is the appropriate reaction to people who contact Samaritans who might be in one of the groups that research has identified as high risk. Samaritans has recently reported an increase in contacts that are financially related (Samaritans Ireland, 2011). Is it feasible or sensible for the Samaritans to alter their longstanding approach to callers by becoming more adept at helping people think through financial problems as well as emotional problems? There may be potential for increased co-operation between Samaritans and organisations such as the Money Advice Budgeting Service (MABS) in Ireland.
A second issue is how Samaritans might encourage more people from high risk groups to contact them for help. This will require the targeting of information about the organisation and its benefits to people in such groups. But that is only a first step. It is one thing to hand out a card to people who have been laid off with contact details for organisations such as Samaritans; it is another entirely to think about why many people who die by suicide choose not to seek support or not to reveal their thinking in the weeks or months before their death.

The last issue concerns Samaritans' role as an advocacy organisation for suicide prevention policies. The key lesson in the economics literature is that, while many suicides are associated with mental illness, there are also many suicides whose immediate and long term causes lie in economic factors such as unemployment and socio-economic deprivation. This point has not been adequately recognised in suicide prevention strategies which tend to be dominated by psychiatric and mental health research.

In the absence of compelling evidence on any particular suicide prevention policy Samaritans should continue to advocate for greater financial and employment-related support for men who become unemployed during a recession such as the current one while also advocating that more attention should be paid to the long-term health consequences of socio-economic inequalities.

Endnotes

1. Social fragmentation in this analysis was derived from census data on private renting, single person households, unmarried persons and mobility in the previous year.

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Male suicide in mid-life: linking private troubles and large social processes

by Julie Brownlie

Abstract

This report takes as its starting point the idea that we can add to our understanding of suicide among men from lower socio-economic groups in mid-life, and its prevention, by linking this most 'private trouble' to larger socio-cultural processes. Drawing on a rapid review of mainly sociological research evidence relating to the broad areas of social change and personal relationships, emotions talk and mid-life, the report is based on a wide-ranging (but non-systematic) review of sociological research relevant to these themes. In light of the significance of talk and relationships for suicide prevention, the report focuses on two specific social changes: the assumed shift towards living in a more emotionally expressive society and the changing nature of personal relationships. By thinking of mid-life not just in terms of age/life stage, but also as a generational and cohort position, and through shifting our lens from the individual act of suicide to the socio-cultural terrain of men's emotional lives generally, it identifies aspects of the mid-life experience that might inform the work of support agencies in helping these men to 'keep on the road'. It argues that there are important questions to be asked about the significance of being in mid-life at this particular historical time; the relative impact of gender and class on men's beliefs and practices relating to emotions talk; the impact of demographic and relational shifts on men's personal relationships; and who it is that men turn to and the nature of the support they seek.

Introduction

The task for sociologists attempting to understand suicide – one of the most individual of acts – is to link 'private troubles' (Mills, 1959) with 'big structures' and 'large social processes' (Tilly, 1984), and to find ways of doing so that are historically and culturally sensitive.

This report takes as its focus not the act of suicide itself – the ultimate manifestation of 'private trouble' – but the broader emotional culture within which that act takes place, and the ways in which that may (and may not) be changing. It is not directly concerned with the aetiology of suicide among middle-aged men in low socio-economic groups – in other words, with tracking backwards from that act to determine individual causes – but with a mapping of the terrain of men's emotional lives in mid-life in order to illuminate the context within which such acts occur.

To that end, the first part of this paper identifies three overlapping ways of thinking about mid-life – as age/life stage, as generational position and as generational identity/cohort – and suggests that each needs to be seen as potentially historically specific.

The second and third parts of the paper apply these three lenses to two specific aspects of men's emotional lives in mid-life which have direct

relevance for suicide prevention: first, the extent to which men are comfortable with (and dependent upon) different forms of 'emotions talk'; and, second, the nature of men's emotionally supportive relationships (who it is that they turn to or talk to in times of emotional difficulty).

The report concludes by looking at possible implications of this multidimensional approach to mid-life, and these social and cultural shifts, for how men in their middle years, particularly those from lower socio-economic groups, manage – or fail – to 'keep on the road' (Frank, 2007), and the role services play in helping them do so.

The overall aim of this report is to illuminate the broad social context of men's emotional lives in mid-life. It therefore draws on thorough searches of the key social science databases relating to social changes, personal relationships, masculinity and the middle years, rather than on a systematic literature[1] review, which would need to focus on a much narrower and specific research question.

Section one

Context: troubling mid-life

Apart from periodic journalistic interest in the notion of the mid-life crisis, the middle years have traditionally been viewed as the prime of life, a time of optimal functioning (Keyes & Ryff, 1998) and hence not of direct policy interest. Indeed, we have come to think of adulthood as embodying exactly those characteristics – independence and autonomy – deemed missing from other life stages, such as childhood and older age (Hockey & James, 2003). This version of the middle years has been troubled by a mounting concern from mental health practitioners and policy makers about the apparent dip in subjective wellbeing (ONS, 2012), and strong evidence of mental ill-health, in this age group, including high rates of male suicide. These concerns are magnified by the 'rectangularisation' of age distribution in the population, so that a greater proportion of people are now in middle and old age than in childhood (Willis & Martin, 2005).
The current middle-aged cohort is, in fact, the largest ever (Demey et al., 2011).

So what is it about the experience of mid-life – and male mid-life in particular – that produces these emotional vulnerabilities? To answer this question, we need first to engage with the different ways of conceptualising mid-life intimated above.

Defining mid-life

In everyday life the notion of 'middle age' tends to be defined in terms of chronological age, but its precise boundaries are blurred and subject to change over time, reflecting shifts in the timing of the physiological changes and life-course tasks that underpin such definitions. Before the twentieth century, middle age was seldom viewed as a distinct period of life. But as longevity has increased, and the middle phase of life has become extended, distinctions have begun to be made between 'early mid-life' and 'late mid-life', with some suggesting the latter now extends to 70, reflecting later retirement and greater 'active' life expectancy. This fluidity and confusion about age brackets and categories is mirrored in suicide statistics and makes it difficult at times to separate out the trends affecting those in their twenties from those in their forties or even fifties.

So age and life-stage definitions are less concrete than they at first appear, and cannot be wholly disentangled from notions of generational position and cohort – two concepts that are often conflated but which, following Pilcher (2005), I have chosen to differentiate.

When I use the term generational position, I am drawing mainly on a particular understanding of the term from kinship studies – one that refers most obviously to the relations between child, parent and grandparent. Cohort, on the other hand, is a demographic term in origin and refers to a population that experiences the same significant events at a given time, i.e. birth, leaving school, the war years. These shared experiences can lead to an ideologically distinct group, which in the terms of the sociologist Mannheim (1952) would also be referred to as a generation. In Mannheim's framework, individuals born in the same historical and cultural

context, and who are exposed to particular experiences during their formative adult years, have a sense of generational identity, although this will be shaped by geographical and cultural location and may well contain opposing groups. An obvious example would be the sixties generation.

Interacting with these chronological, cohort and generational positionings are period effects – an obvious instance of this currently being the effect of the economic crisis. Age, period and cohort influences are not easy to disentangle (Brockmann, 2010), but the relationship between these different temporalities raises important questions for how we think about men in their middle years. As suggested by the Arab proverb, 'A man resembles his times more than his father' (cited in Hagestad, 2009), we need to understand how our beliefs and behaviours might reflect our time (cohort and period), our parents' beliefs (generation) and simply the cycle of life. In the remainder of this first part, through drawing on life stage, generational position and cohort concepts specific to mid-life (the 'u curve', the 'sandwich generation' and the 'lucky cohort') I begin to identify some of the distinct challenges of the middle years at this historical time.

Mid-life as life stage: the bottom of the 'U curve'

While the empirical evidence for a mid-life crisis has always been weak (Deeg, 2005), there is a growing, if not altogether uncontested, literature on the so-called 'u curve' in wellbeing across the life course. The argument here is that subjective wellbeing follows a curvilinear age trajectory – a u curve – being lowest during mid-life (Blanchflower & Oswald, 2008). What is it about this life stage that impacts so negatively on wellbeing, and how is it that people then start to come out of the dip? Although different hypotheses have been put forward, most of these are untested and, to date, have been rather individualistic – for example, that, as we leave middle age, we learn to count our blessings or curb our aspirations (Blanchflower & Oswald, 2008).

One argument, the social investment model, focuses on mid-life as a time when the consequences of long-term decisions about when, how and how much to invest in the labour market and in relationships come to light. This is also the time when the possibilities for making changes in these domains are limited, and likely to come at a high cost (Brockmann, 2010). Shiner et al. (2009) make the same point in their study of suicide in mid-life, emphasising men's investment in social relationships and work, and the concomitant risk to men when these break down, through either work stresses or relationship problems. Where children are involved, they note that such relationship breakdowns are also likely to have an impact on men's identity as fathers and their sense of belonging. The literature on wellbeing supports this, identifying a change in partnership status as a key factor affecting wellbeing in the middle years (Deeg 2005). I return to this point below, when looking at the current cohort of mid-lifers in the context of the rise in solo living[2] (Jamieson et al., 2009).

Shiner et al.'s emphasis on work is also supported by research evidence about the impact of unemployment on subjective wellbeing and the connection between unemployment and suicide risk,[3] as well as the serious consequences of cumulative unemployment for those in mid-life (Brockmann, 2010), particularly those with few or no qualifications (Demey et al., 2011). Sociological research has linked work, class and 'respectability' (Skeggs, 2004): for men from lower socio-economic groups, respectability in mid-life is closely connected to these life-stage demands of work and family. Recent work looking at class and emotions can also be usefully drawn on here, specifically that which focuses on shame (Skeggs, 1997). Sayer (2005) compares shame – seen as a response to real or imagined contempt or avoidance, particularly by those one respects (this part is crucial: it is not enough to incur external social disapproval – one has to care about it) – and self-respect, which derives from a feeling that one's life is worthwhile. For Lamont (2000), in her study of French working-class men, this sense of self-respect derived from being able to work hard and to provide for and protect their families.

Charles et al. (2008), in their 2002 study of family life in Swansea, found that, despite women's increased

economic activity, far more men than women regarded themselves as the main breadwinner; and the male breadwinner ideology still had purchase even when men's occupational status was lower than that of their partners. In their study, men who became unemployed had a less central position in kinship networks to fall back on than women, and so found themselves marginal both to the labour market and to family networks.

Although these feelings of shame, and of belonging or mattering, are difficult to articulate (Charlesworth, 2000), class inequalities mean that the social bases of respect – access to valued ways of living – are unevenly distributed (Platt, 2011; Sennett, 2003). Hence our need for self-respect or recognition (Sayer, 2005) always carries the risk of our being shamed, and this is heightened for those of lower socio-economic position. In addition, this might be particularly true for the current 'lucky' cohort of mid-lifers who, as we will go on to see, may be more aware of their peers having a way of life they themselves have not achieved.[4]

Mid-life as generational position: the 'sandwich generation'

As well as these overlapping life-stage, period and cohort effects, it is illuminating to think about the generational position of those in mid-life. Most people in mid-life now have family that spans several generations. Hence the importance of thinking about linked lives. For most of their adulthood people belong to two sets of parent relations, and to that extent are Janus-faced. The rise of the so-called 'beanpole family', as a result of reduced fertility and extended longevity, means that ties are often stronger vertically than horizontally (Hagestad, 2009).

We need to be cautious, however, about making claims about the impact of the so-called sandwich generation – those who are simultaneously caring for their children and possibly grandchildren, as well as their elderly parents, and/or those who care for dependants and also work – because of the need for reliable information on the size of these groups, and the proportion of each that actually feels burdened (Daatland et al., 2010). Depending on one's family structure, labour market participation and expectations about family and work, one's experience of being in mid-life (including whether or not one is 'sandwiched') may vary greatly (Kohli & Kunemund, 2005). Gender remains a crucial determinant of the experience of being sandwiched, as it is still predominantly women who manage care for younger and older generations – although men are, of course, often part of this increasingly complex equation of balancing work and care.

The recent report by Demey et al. (2011) on mid-life, mentioned above, notes that fewer people in mid-life in the UK now have a child or grandchild than ten years ago, while more have a parent or grandparent. Among those who have children, there has been a shift from living with young children in our twenties and thirties to doing so in early middle age (age 40–49). These shifts will have significant implications for the demands on, and the supports for, men who are now in mid-life, as they age. So, too, might another significant trend affecting men in mid-life in the UK: the rise of solo living (Demey et al., 2011). I will return to the issue of how these social changes that shape personal relationships affect the current cohort of men in mid-life.

The middle years as a cohort: the lucky ones?

While there has been some attempt to think about suicide, including mid-life suicide, in terms of the life course, this has been more focused on life-stage explanations (Shiner et al., 2009). In other words, research has been focused on the problems associated with stages of the lifecycle – youth, middle age, older age – rather than on the way these stages, and their associated roles and problems, vary across historical time. We know, however, that the challenges facing those in mid-life are not static, and therefore there is also purchase in thinking about men in their middle years in cohort terms.
We saw above that the notion of cohort refers to a particular subpopulation which ages together and is shaped by shared experience, leading potentially to the emergence of a historically specific group with a distinctive generational identity (Mannheim, 1952).

For example, the original baby-boomers, born in the 1950s, are sometimes characterised as the 'lucky cohort' (Brockmann, 2010), having experienced, for example, prolonged economic growth and the rapid expansion of the welfare state. These 'lucky' mid-lifers, however, may also feel under pressure to 'do the right thing' (and feel more visible if they fail to do so) and, given the size of their cohort, find themselves in competition to meet the above life-stage demands relating to work and relationships – a situation exacerbated by the current economic crisis. It is these life-stage demands as experienced by this cohort that led Brockmann (2010) to label these mid-lifers 'frustrated achievers'. A second cohort (equal in size but drawing less attention) can also be identified from those born in the 1960s. Picking up on the theme of unfulfilled expectations and of envious awareness of peers, this group is sometimes referred to as the 'Generation Jones' (as in 'keeping up with') and is under-researched in the context of public mental health (Williamson, 2008). There may even be a distinct third cohort entering mid-life, the so-called Generation X, born in the first half of the 1970s and popularly associated with a more disaffected or alienated perspective.

Previous work has suggested a clear break between pre- and post-war generations in terms of how they manage their emotional lives and their attitudes to support services (Anderson and Brownlie, 2011) – the difference between the pre-war 'silent' and the post-war 'me' generations. In this context, the notion of the 'buffer generation' (Mannheim, 1952) – the generation caught between more traditional and progressive cohorts – could help us make sense of the ambivalent emotional practices of the current cohort of men in their middle years, an issue explored further below. But if, in fact, several identities or cohorts coexist, even within the period we currently think of as mid-life, a more nuanced analysis of the implications for mental health is needed, especially as these cohorts are defined in highly affective or psychologically vulnerable ways – that is, as the 'me' (baby-boomer), 'envious' (Jones) or 'cynical' (X) generations.

Since the 1970s, several important social changes have impacted on all of the current mid-life cohort's personal lives, including increases in female employment; births outside of marriage; divorce and cohabitation; lone-parent households; second and subsequent marriages; step-families and solo living. For some, these point to a restructuring of family relationships that is likely to lead to long-term modification of family patterns, and so are indicative of historical rather than cohort change (Allan et al., 2011, p. 2). Some have argued that a number of these shifts, for instance rising divorce rates and changing work patterns, signal a changing gender order, which has been linked to mental health problems in men – the so-called crisis of masculinity thesis (Möller-Leimkühler, 2003; MacInnes, 1998). Regardless of the accuracy of such claims, these changes highlight the need for an explicitly relational approach to understanding male suicide.

This means grappling not just with the demands associated with generational position, including for this cohort the implications of the potentially fraught relationship between those in mid-life and their 'emerging adult' offspring (Arnett, 2004), but also with other social changes that have affected this cohort's personal and family relations. These include addressing the complexity of kin relations that follow from de-partnering and re-partnering (Charles et al., 2008, p. 66). The complexity of such 'un-clear', as opposed to 'nu-clear', families (Simpson, 1998 cited in Allan et al., 2011, p. 34), however, highlights the extent to which, despite the fluidity of partnering, kin and family relationships remain important. Given the breadth of this report, but also the relatively sparse published literature on the subject, it is not possible here to offer a comprehensive analysis of how experiences of de-partnering and re-partnering are shaped by class.[5] Some research studies do, however, illuminate the particular ways some of these changes may play out for men from lower socio-economic groups. Charles et al. (2008), in their study of family life in Swansea (a re-study of research carried out in the same area in 1960 by Rosser and Harris,1965) found, for example, that kinship contact remained greater for working-class than for middle-class families, not just because the latter live further from kin, but also as a result of the demands of middle-class careers (Chambers, 2006). They also noted that, although contact with kin across all socio-economic groups is always greater for women, between 1960 and 2002 working-class

men's contact with their fathers appeared to decrease, and was lower than that between their male middle-class counterparts (2008, p. 149). Although we need to be cautious about generalising from one study, or of making claims that the number of men who lose all contact with their children is increasing (Jamieson et al., 2009 suggest there is no evidence that this is the case), so-called 'absent fathers' have been linked to the rise in lone-parent families and divorce or separation. Charles et al.'s qualitative data suggest that, when fathers come to live in different households, there can be conflict around new relationships. Not surprisingly, Trinder et al. (2002) noted that less conflictual relationships were associated with men managing to maintain contact with their children. Higher income and education, divorcing rather than cohabitating or 'never (lived) together' parents, fathers living in close proximity and the payment of child support were also associated with greater contact. This link between contact and payment of child support is also highlighted through recent analysis of Understanding Society[6] data (Ermisch et al., 2011). In some cases, however, the lack of contact in Charles et al.'s study was not about conflict but about such contact being seen as disruptive to new family set-ups. This left some of the fathers in the Swansea study upset and feeling they were being denied the right to see their children.

The current economic crisis is likely to exacerbate some of these tensions. Blekesaune (2009), for example, in her analysis of the British Household Panel Survey, found that unemployment increases the risk of partnership dissolution for men and women, while Ermisch et al. (2011), in their recent analysis of Understanding Society data, found that being out of employment for men was associated with lower levels of happiness in their relationship with their partners.

Charles et al.'s interview data also suggested that in working-class communities, although close-knit networks could be the key to survival in times of financial hardship, inter-family conflict was also common. Other research on parenting (Bagnell et al., 2003; Gillies & Edwards, 2006) has also compared the denser relationships among working-class parents with more diffuse middle-class networks, where there are fewer obligations. It is the higher expectations and emotional intensity of the former set of relationships, Gillies and Edwards (2006, p. 49) suggest, that can lead to 'narratives of betrayal, disloyalty and estrangement'. Spencer and Pahl (2006) also note the breadth of middle-class networks, but at the same time point to the increased value attached to friendship across all classes.

The above discussion on partnering and de-partnering links to another significant social change intimated in the last section: the rise in solo living. The increase in living alone in middle age has been greater for men than for women: fewer middle-aged men than women were living alone in 1984, but by 2007 men had caught up (Demey et al., 2011). Between 1984 and 2007, for example, the percentage of men aged 35 to 39 living alone increased from 6% to 15 % (Falkingham et al., 2012). Among people of working age, men are more likely than women to live by themselves: 16% of men aged 25–44 were living alone, compared to 8% of women of the same age (Smith et al., 2005).

Falkingham et al. (2012) note that, of those who do live alone, most have been in a co-residential partnership at some stage: among men aged 45 to 54, for example, three-quarters (75%) have been in a previous partnership and almost four in ten (37%) have been in multiple partnerships. And not surprisingly, albeit interesting given the discussion above about the changing nature of fathering, a significant proportion of men living alone have non-residential children (e.g. 46% of those aged 45–54). It is also worth noting that Falkingham et al. (2012) found that the 'never partnered' middle-aged men are considerably more economically disadvantaged than their female counterparts.

Although we cannot equate living alone with being lonely (Smith et al., 2005), there are aspects of living alone which suggest that men in this position are at a disadvantage. Specifically, those living alone are less economically active, with a significantly larger proportion being permanently sick or disabled, more likely to report poorer health, and to smoke and drink; and to have lower access to home ownership and higher use of social housing (Smith et al., 2005;

Jamieson et al., 2009). Crucially, in thinking about those men who are vulnerable to suicide, those who are living alone may also have less access to informal care and family support. The balance between friends and family in the social network of those living alone is towards the former, and there are strong gender differences here. Men living alone, despite often being sociable, are less likely than their peers to have anyone with whom they can discuss intimate and personal matters (Jamieson et al., 2009). Thinking relationally, as we will see below, then, involves conceptualising intimacies or connections which are inclusive of – but not restricted to – family, kin and partners (Ribbens McCarthy, 2012; Smart, 2007; Roseneil & Budgeon, 2004; Jamieson et al., 2011).

It is not only that those living alone are disadvantaged in the ways outlined above: rates of solo living are also higher among middle-aged men who are socially and economically disadvantaged. An unpublished analysis of data from the Scottish Household Survey[7] for the period 2007–2010, for example, indicates that 28% of men aged 40–59 in the most deprived quintile live alone, compared to just 8% in the least deprived quintile. The former are also more likely to live alone than are women of the same age in the same areas (18% of whom do so).

There is a need for further research to understand why men end up living alone, given that there is some evidence that this is more likely for men than women to result from choice than from circumstances (Jamieson et al., 2009). Whatever their motivation, however, given the risks for men in lower socio- economic groups who do live on their own, these recent trends in men's partnerships and living arrangements are significant. This is particularly so if, as will be argued below, men of all ages and classes continue to remain dependent on women – mothers and then partners – as their main emotional conduits. Before exploring these relationships, however, I look at how this current cohort of mid-lifers has been affected by socio-cultural shifts relating to our emotional lives, particularly the cultural acceptance that it is 'good to talk'.

Section two

Men and emotions talk

For those involved in suicide prevention, a key challenge remains how to encourage those at risk to seek help as early as possible. The inability to express distressing emotion has been viewed as a risk factor for suicide (Cleary,2012; Clare, 2000), and the argument that some forms of masculinity position men as stoical and unwilling to seek help has meant that emotions talk by men has come under scrutiny (Courtney, 2000; Ridge et al., 2011; O'Brien et al., 2005).

Cultural beliefs and practices regarding talking about emotions do matter, then, but what do we know about these? Academic and media accounts present us with contrasting stereotypes about shifts in beliefs and practices in relation to emotional lives in Britain. On the one hand, 'the British' continue to be portrayed as emotionally closed and suspicious of the overly emotional traits of other nationalities (notably North Americans). On the other hand, commentators and academics increasingly claim to detect an emergent 'therapeutic' culture, where the suggestion that it is 'good to talk' has become a moral imperative and where there are increased disclosures about our emotional lives (Furedi, 2004; Illouz, 2007). A recent national study of emotional lives, The Someone To Talk To Study,[8] provides some support for the latter proposition. As this was the first national survey to explicitly address these issues, there is an absence of time-series data that would allow the pace and direction of social change to be conclusively documented. Nevertheless, its cross-sectional analysis does allow for an examination of differences in attitudes and beliefs across age groups, and the nationally representative character of the sample also allows for an examination of the ways such developments can really be said to be universal. In fact, the variation in attitudes towards emotions talk across different sections of the British population noted in the study proved to be so great that it makes little sense to think in terms of a single, undifferentiated 'emotions culture'. The two most important dimensions of this variation, age and gender, are the focus of the rest of this part of the report, as is their interplay with

class. I will consider the implications of all of this for suicide by men in their middle years below.

Findings from the STTT study suggest that, regardless of changes in actual emotional practice, there is at least a widespread perception in Britain that emotions are now discussed more freely than in the past (Anderson et al., 2009). The study also suggested a very clear age dimension in attitudes towards emotions talk. In short, those born roughly before the end of the Second World War exhibit attitudes that are much more sceptical than those of subsequent age groups about the value and importance of talking about one's feelings. This may well be an indication that a widespread cultural commitment to emotional restraint is, quite literally, dying out in Britain. However, it would be a mistake to see this process of cultural change as straightforwardly unilinear, undifferentiated and rolling unstoppably through contemporary society, carrying all in its wake. The picture is, in fact, more complex, and different groups engage with – and resist – this type of emotionally expressive culture in a variety of ways, some of which may contain elements of contradiction (Brownlie, 2009). Middle-aged men – the focus of this report – are, as I discuss further below, a case in point.

As might be predicted from work on masculinity over the last decade or so (Connell & Messerschmidt, 2005; Kimmel, 1994; Whitehead, 2002), the STTT study found that men, both in general and of all ages, continue to exhibit very different attitudes to talking about emotion from those of women. Some have posited recently that there has been a move towards androgenisation – a convergence of men's and women's emotionally expressive skills – as a result of a shift towards elevating 'female' and 'therapeutic' skills in the work and personal spheres (Illouz, 2007). However, as we will see, most empirical research on men's help-seeking has repeatedly found this not to be the case. There is little evidence from the STTT study of a uniform pattern of gender convergence in relation to emotions talk in Britain: women generally remain much more positively oriented towards such talk. However, as will also be discussed, we need to remain aware of the distinction between what we say about talk and what we actually do.

The most important fact about middle-aged men in lower socio-economic positions in relation to their beliefs and practices about talking about emotions, then, would seem to be that they are men. But age and socio-economic position are not completely irrelevant here, and layer on to the effects of gender in subtle and interesting ways.

Those currently in mid-life have grown up in an era in which emotions culture has been changing. Unlike those born in the first half of the twentieth century – referred to above as the 'silent generation' – they are less likely to maintain a stoical 'mustn't grumble' attitude in the face of emotional difficulties. Certainly, their own children will have broken decisively with such a culture. Yet they themselves sit somewhere between the emotional austerity of their parents and the apparent openness of their children. This is a finding supported by recent sociological work on first-time fathers, where there is a sense of men caught between new identities based on the ethos of involved fathering, and the pull of what Coltart and Henwood (2012, p. 36) call the 'vexed inheritance' of classed masculinities. Men in mid-life more generally are well aware of the 'good to talk' cultural imperative and the risks of seeming not to engage with this, particularly when encouraged to do so by partners. Yet, at the same time, they have a deep feeling of unease about doing so. To that extent, these men's cohort position is distinctive, and potentially a source of tension, which is accentuated by men's limited range of social relationships during the life stage of their middle years (see below).

The effects of social position on talking about emotions are difficult to disentangle. Research to date has suggested a strong class element (Seale & Charteris-Black, 2008), though a cautious note has also been struck about the extent to which middle-class men, when they do engage in emotions talk, maybe 'talking the talk', given that performing emotional reflexivity of this kind is, in itself, a form of capital – in other words, a resource in its own right (Skeggs, 2004). Moreover, we know that not all men from lower socio-economic groups are emotionally inexpressive (Walker, 1994) or indeed vulnerable to suicide (Cleary, 2012). Data from the STTT study suggest that, perhaps contrary to popular

stereotypes, men from lower socio-economic backgrounds are not especially resistant to the idea of discussing their feelings – at least, no more so than their middle-class counterparts. Despite theoretical claims about class differentials in relation to emotional reflexivity, this study found little difference across social groups in relation to general orientations towards emotions talk, or the frequency with which these men actually talk to those close to them. Where there were clearer differences, was in relation to knowledge and understanding of formal therapeutic support – a point to which I return below.

The above discussion suggests that, for men in their middle years from lower socio-economic backgrounds, what matters most in terms of their beliefs and practices about emotions talk, is their gender, generational and cohort position. This is not to argue that class is irrelevant – far from it. A growing body of research on unemployment and suicide, as we have seen, makes clear that such socio-economic vulnerabilities put men from these groups at particular risk – and, as I will explore further below, it seems that there are educational and income effects in relation to knowledge of support services. The point being made here is simply that the focus, when thinking about the significance of class, is perhaps better directed at these differentiated socio-economic vulnerabilities than at less prominent class differences in the emotional talk by men.

Section three

Being there: who men turn to at times of emotional difficulty

The above discussion cannot be understood without understanding the significance of a second key social shift: the changing nature of personal relationships. In the last twenty years there has been a considerable amount of sociological research into the changing nature of our personal lives. I now build on this work, the above exploration of mid-life in life stage, generational and cohort terms, and men's beliefs and practices about emotions talk, to better understand who men in their middle years turn to at emotionally difficult times, either within their own personal networks or professionally, and the nature of the support they seek.

As already noted, we know from research that personal relationships have a powerful effect on wellbeing and that they are probably one, if not the main, factor that correlates most strongly with mental wellbeing (Reis, 2001). Several key arguments which have developed out of sociological research on the impact of social change on our personal lives in recent years are relevant here. First, and most prominent, is the argument that our personal lives are being shaped by processes of individualisation (Beck 1994; Beck & Beck-Gernsheim, 2002); in other words, that, relative to previous generations, who found themselves bound by traditions and social structures, our personal lives now are more in our own hands. Individualisation, so the argument goes, has involved a shift away from established patterns of socio-economic dependency towards greater individual choice in negotiating our own biographies. Developments such as the increase in solo living, cohabitation, divorce and gay partnerships have been positioned as a part of this democratisation or transformation of intimacy (Giddens, 1992). Some of this work has been roundly criticised for underplaying how constraints, including socio-economic location and gender, continue to shape our personal lives (Jamieson, 1999). Second, and relatedly, there has been a growing interest in the way our understanding of what constitutes family has stretched beyond household and kin to include ideas of 'kin-like' relationships or 'elective affinities' (Beck-Gernsheim, 2008). These personal networks can be inclusive of all sorts of relationships beyond those we have traditionally thought of as 'kith and kin'. A third theme relevant to this report is a questioning of what constitutes intimacy: specifically, whether intimacy needs to involve talk or disclosure and be linked to explicit knowing, or whether we need to look more at how intimacy emerges through the practical aspects of care and is a product of living shared lives (Jamieson, 2011).
To what extent, then, do these themes of individualisation, and reframing of who are intimates and what intimacy is, speak to men from lower socio-economic groups?
As indicated above, despite social scientific

theorising about our living in an increasingly individualised culture, empirical research makes clear that webs of informal emotional support continue to play a major role in the lives of the majority of the population (Anderson et al. 2009). Whether in a relationship or not, most people have other people around them to whom they say they could and would talk if they were feeling worried, stressed or down. Albeit not wishing to reinforce a 'hierarchy of intimacy' (Budgeon, 2006) or to deny the diversity of the networks of relationships we belong to, this emotional support continues to be sought, and given, against a backdrop of relationships with partner, friends and family. This does not mean that these relationships are not in themselves distinct from each other, or that they are not differentiated by class, age and gender, as well as by other variables. It is not possible here to pull out all these differences systematically, but there are some key points worth making in relation to men in mid-life.

First, women continue to feature more prominently than men in both men's and women's accounts of others 'being there' for them – whether this is as mothers, partners, daughters, siblings or friends. Across the life course, both men and women are generally more likely to say they would turn to female siblings than males ones, to female friends rather than male ones, and so on. Across the age groups in the STTT study there was a stubborn perception that women are better listeners and more empathic than men, though this was less so among the oldest age group, who seek less emotional support in any case.

The second point to note, however, is that patterns of who people turn to are obviously not constant across the life course. In particular, the STTT study suggests, they are greatly affected by processes of partnering and de-partnering. Across the life course, acquiring and losing partners is hugely important in terms of patterns of who people turn to, but this too plays out slightly differently for men and for women. Among men, from the age of 30, partners assume an overwhelming and consistent importance that lasts through subsequent years. The proportion of women relying on partners does increase, but not as much, and drops away again in the oldest age group, presumably as many become widowed. Unlike younger men, who are likely to have a wide circle of friends but perhaps not yet a partner, men in mid-life tend to be overwhelmingly connected to, and dependent on, their partner for emotional support – far more so, it seems, than women of the same age, who tend to maintain close same-sex friendships and may develop relationships of mutual support with adult children. This pattern of male reliance on partners is confirmed by recent analysis of Understanding Society data (Laurie, 2012).

Different patterns also emerged in terms of reliance on same-sex friendships for men and women across the life course. Among both men and women under 30, 13% in the STTT study reported that a same-sex friend would be their first port of call in the face of emotional difficulty. Among men this drops right away in subsequent age groups, whereas for women, female friends maintain a broadly consistent presence across the life course.
While these life-course effects are largely a result of patterns of partnering and de-partnering, they are of course overlaid by distinctive generational differences, as discussed earlier. As with the demographic shifts towards solo living, particularly among men in their middle and older years, this pattern of friends dropping away across the life course becomes, as we saw earlier, potentially problematic when men experience emotionally difficult times.

Reflecting long-standing findings from previous research about the significance of perceived, as well as actual, social support (Barrera, 1986), men in the middle years may also come to perceive themselves to be without support, for example following separation, or after long periods of being out of work. Compounding this, men may allow such feelings to build for some time before realising that they are vulnerable (Cleary, 2012). This is the connection between traditional constructs of 'masculinity' and the so-called 'big build' processes described in other research on suicide in men (Brownhill et al., 2005). Some researchers have suggested that men's lack of emotional knowledge is rooted in beliefs developed in childhood about the association of emotional openness with weakness (Addis & Mahalik, 2003). Not having been socialised

in emotional skills, some of these men may then enter relationships where there are few, or no, opportunities to develop such skills, not least because of the prevalent cultural assumption that women 'do it better' (Mirgain & Cordova, 2007).

From the above, it is clear that, across different age groups and classes, women maintain a key role in men's emotional relationships. What is also apparent is the way that life events and stages interact with these dynamics to make the narrowness of men's emotional connections in mid-life a potential source of vulnerability.

Yet, there is also evidence that, while men may fear male friends finding out about their mental distress (O'Brien et al., 2005), these friendships are also valued, and in some settings (Singleton, 2003) and at certain times, may be a significant source of emotional support. In the STTT study, few of the men interviewed described close male friends to whom they spoke on a regular basis about emotional issues. More men did, however, describe friendships that were emotionally significant, even if they did not involve talk, and crisis times, such as a partner's miscarriage, when they did speak to particular male friends.

For those men in the STTT study who did mention talk, often what they were describing was a need to be listened to rather than be given advice. Specifically, they describe seeking out those in their network who they perceive as non-judgemental and who, crucially, know them and the background to the stories they are telling. In other words, they seek unconditional acceptance, summed up by the phrase 'no questions asked'. For many, what also matters is that this talk goes no further: that the listener will neither ask questions nor repeat what they have heard. Moreover, in the STTT study, where emotional talk did take place between men, it was often presented as spontaneous. For the most part, however, activities such as listening to music or exercising were more to the fore than talk in men's accounts of managing stress or worry.

What counts as support

Many men (and women) in the STTT study, when asked about what counts as emotional support, referred to relationships which were extant, background or taken for granted. These relationships were described in terms of others 'being there' for them (Brownlie, 2011). This might involve the range of things that people do for each other, including practical or monetary help, but it was also about reachability, either in practice (people who phone them at same time every day or night) or in principle (people they have in mind that they could ring up in the middle of the night should they need to). Participants in the STTT study also emphasised 'being there' as 'being alongside' – friends or family staying with them after bereavement, or, as one person from the study put it, being there to 'play out the time of depression'. In practice, this often means having permission not to talk about known problems or losses. Finally, 'being there' was also understood as someone else understanding what they are feeling, with this insider knowledge coming from knowledge of the experience and/or of the person themselves. Over time, this knowledge and sense of there-ness are jointly lived and constituted. Men, in the STTT study, however, also highlighted that just knowing another person was not enough for them to feel they could offer support: in order to effectively be there for others some men felt they had to have gone through a similar experience themselves.

We need to be cautious of underestimating the ways in which men do intimacy and offer support both to other men and to women. It has come to be taken as read that men's friendships, for example, are of a different order from women's: less based on self-revelation and nurturance, and more concerned with 'doing' and 'being alongside' (O'Connor, 1992; Rubin, 1986; Nardi, 1992). It is easy for this difference to be read according to feminised scripts of intimacy, and for men's relationships then to be found wanting (Cancian, 1987). Moreover, not all women have intimate relationships, and, as we have seen, some men do: there are differences between men, and between women, depending on age, but also, specifically, on class (Walker, 1995). At the same time, we also need to be cautious not to conflate the telling about friendship, which is often

gendered, with the actual 'doing' of friendship, which may not be as gendered. In other words, in telling particular stories about their male friends men could be performing a type of masculinity (Walton et al., 2003; Smart, et al., 2012) that emphasises differences between men and women (Walker, 1994). Working out the relationship between what we say and our actual beliefs and practices is not straightforward.

Professionalisation of emotional lives?

Use of formal talk-based support remains relatively rare in the UK (Anderson & Brownlie, 2011; Brownlie, 2011a). It is true that a significant proportion of all adults have, at some stage, consulted their GP when they have been feeling 'worried, stressed or down', but there is little sign of widespread recourse to explicitly talk-based forms of emotional support (psychiatry, psychology, counselling or therapy). From the STTT study it is clear that only 16% had any experience of talking to such professionals, and only 6% had done so within the past year (Anderson & Brownlie, 2011). There is not space here to examine in detail patterns of variation in actual service use across different sections of the population, but in relation to men in their middle years from lower socio-economic backgrounds, three broad patterns are worth noting.

The first relates to age. Resistance to ideas of professional emotional support is greatest among the age groups exhibiting the highest levels of life satisfaction (the young and the old). By contrast, those at the bottom of the so-called 'u curve', i.e. in their middle years, are the most open to such ideas. This peak of formal service use in middle age, then, perhaps reflects need: as we have seen, the 'u curve' in wellbeing suggests that one's middle years are the most difficult in emotional terms, and it is, of course, important to note in this context the link between depression and suicide (Gonzalez, 2008). However, it is likely that there is also a cohort effect here: in other words, that the emotional difficulties experienced in mid-life by those born in the period roughly between 1945 and 1965 are coinciding with a greater sensitivity to, and awareness of, counselling and its possibilities. The figures for 'last year' use of talk-based therapies among the youngest age group suggest that demands on these services will continue to rise, as larger numbers of people will enter their 'difficult' middle years with existing experience of talk-based emotional support (Anderson et al., 2009).

The second pattern relates to gender. As we saw above, overall, men are much less likely to have a positive orientation towards emotions talk in general, and also towards the idea of formal support in the face of emotional difficulties. The gendered nature of help-seeking (Cleary, 2012) and the ways particular constructions of masculinity restrict men's willingness to seek help (O'Brien et al., 2005; Noone & Stephens, 2008), with concomitant consequences for their health (Courtenay, 2000; 2003), have been well documented. Again, however, there is a need to be cautious about shoring up gendered binaries: as we have seen, not all men are emotionally restricted, and not all women are emotionally open (Canetto & Cleary, 2012). For some men, for example, emotions talk is a way of taking action, and for others, as we saw above, crises such as bereavement can change their outlook (Ollife, 2005, 2006; Robertson, 2006; 2007).There is also evidence suggesting that women's and men's experiences and attitudes to help-seeking may not be so different (Emslie et al., 2007; Ridge et al., 2011).

Nevertheless, for many men there is still an apparent stigma attached to emotional disclosure and a sense that emotional distress and mental health problems carry significant risks for masculine identity (O'Brien et al., 2005). Ridge et al. (2011) note that some campaigns, such as the 'Real Men, Real Depression' initiative in the US, have deliberately worked with discourses about men as 'providers and protectors' to position help-seeking as manly and courageous. In other words, seeking help for mental distress is positioned as a part of men 'doing health' for the sake of close others. There is also evidence, however, that men tend not to share with partners and wives precisely because they wish to protect and not worry them, and because they believe that women need and want 'strong masculinities' (Cleary, 2012:501).

The STTT study also suggests that men are more likely to think counselling is only for people with very serious problems – a concern, given the big-build processes described above – and to say they do not really know anything about it. They are also less likely than women to say they would feel comfortable talking to a therapist or counsellor, or know how to find one. Yet, although men are much less likely than women to turn to informal sources of emotional support such as partners, friends and family (as we saw above), the gender gap in relation to formal emotional support – and especially in relation to the talking therapies – is less wide. How can we make sense of this? This may be an indication that formal service use is associated with actual need (defined in terms of significant mental health problems, which are experienced relatively evenly by men and women) rather than with what might be caricatured as a more voluntaristic 'project of the self'. Use of formal emotional support remains primarily associated with moments of crisis, and with failure of the usual support mechanisms. As such, the problem is perhaps less about levering men into formal support at times of crisis than about reinforcing their ability to access both informal and formal support in advance of those points of breakdown (Myers et al., 2005), returning again to the need to intervene before the build-up begins.

This, then, is the final key point: the most powerful predictor of use of formal emotional support remains, not surprisingly, poor current mental wellbeing, or experience of serious mental health problems within the last five years (Anderson et al., 2009). In other words, services are generally being accessed by those in greatest need. There is also, in the STTT study, a strong relationship between mental ill-health/wellbeing and measures of social class and income, so one might also expect a higher level of service use among poorer people. But the differences in use of formal support overall are not as great as might be expected, and there is no difference at all in relation to levels of use of more overtly talk-based therapies (such as psychology, psychiatry and counselling). This group is in practice almost twice as likely to have been prescribed drugs in the face of emotional difficulties (Anderson et al., 2009). In other words, it appears that among the poorest (and most needy) sections of British society there is a substitution of a pharmaceutical for a talk-based response to emotional problems. This too, however, is a gendered story, as it is women, specifically, who are more likely to be offered and to accept such medication (see, for example, Blanchflower & Oswald, 2011; Brugha et al., 2004).

There are also clear educational and income effects here. Those educated to degree level and living in more affluent households were markedly more likely to be aware that therapy/counselling is not only for those with serious problems, and to know how to find a therapist or counsellor. Interestingly, however, differences are less marked in relation to apparent willingness to contact such services – in other words, for middle-aged men, higher levels of knowledge or awareness among the better educated and more affluent do not necessarily translate into a greater ease with the idea of seeking formal emotional support. Although such a finding is not unexpected, it nevertheless signals a degree of cultural resistance to – or lack of confidence in – the idea of therapy or counselling among different sections of the population which may actually exhibit a significant need for such services (Shaw & Taplin, 2007). This lack of belief in the efficacy of talk was common among men across socio-economic groups in the STTT study, reflecting the findings of other research (O'Connell & Clare, 2004) and supporting the argument developed above about the need to focus more on gender than class in relation to men's emotions talk.

Conclusion

This report took as its starting point not the aetiology of suicide among middle-aged men in low socio-economic groups, but the broader terrain of men's emotional lives in mid-life, in order to try and illuminate the context within which such acts occur. By applying the lenses of life stage, generation and cohort, it argued that mid-life, while doubtless always having its challenges, has become increasingly complex in light of the cultural, socio-economic and demographic changes engaged with throughout the report.

But these changes do not impact uniformly on all, as the middle years are differentiated not only by gender and age (the notion of younger and later mid-life) but also by socio-economic position. As Featherstone and Hepworth (1989) pointed out some time ago, the middle classes are in a better position to break with more traditional cultural constructions of middle age, creating what they termed a "disparity of prospects" in mid-life'.

Because of the significance of both talk and relationships to suicide prevention, this report has focused on two particular inter-related socio-cultural shifts: those relating to emotional openness and those relating to the changing nature and form of personal relationships.

There is a growing body of sociological work on our personal lives since the end of the 20th century, and the report attempts to harness some of this thinking to illuminate the experience of men in their middle years from lower socio-economic backgrounds. It is clear that a relational view of these men's experiences is necessary. Increasing levels of partnership dissolution and re-partnering contribute to the complexity of relationships experienced in mid-life, including an increase in the number of men living apart from their children. These shifts potentially place men from lower socio-economic backgrounds at risk from a lack of emotional support at a time when they may also be facing considerable economic pressures.

These demographic and relational changes are also unfolding at a time when men in mid-life are having to navigate huge cultural shifts in expectations about how to manage their emotional lives and relationships. For some men, these shifts not only challenge their understanding of what it is to be male, but confront them with the gap between their own experience of being parented and how they themselves now relate to others as partners and fathers. In responding to this group of men, support services might wish to acknowledge more – and even work with – this sense of ambivalence, which comes from being part of the 'buffer generation'. Rather than seeing the choice for campaigns or interventions as being either to engage men through the language of traditional masculinity or to provide them with alternative masculine identities, the aim instead could be to acknowledge that, for many men (especially, though not exclusively, this cohort of mid-lifers), their position is an uneasy one. Rather than being straightforwardly resistant, these men may well be experiencing the push of new discourses of masculinity while also feeling the pull of the old.

Mid-life, which has traditionally been thought of as a time for reflection, could therefore be deliberately and usefully framed as such by services. Ideally this would be done in a way that does not leave men feeling that they have failed on two counts: by having problems and by not initiating help – a risk in a climate where empowerment and participation in health care are increasingly seen as moral acts (Willis et al., 2010).

The report has also highlighted the fact that, while men in mid-life continue to find themselves primarily dependent on women as emotional conduits, they belong to a cohort increasingly likely to be living on their own, with little or no experience of seeking help to fall back on should they need it. In this context, those professionals to whom men do have access, such as GPs, might usefully be made aware of the potential vulnerabilities faced by men at this life stage and in this cohort. The issue here may be as much about men's perceived, rather than actual, lack of support or sense of belonging. This is particularly relevant in the case of separation where children are involved, or where men face long-term unemployment and begin to doubt that there are people who are there for them or for whom they matter.

While service providers need to be aware of this reliance on women, the above analysis also suggests that those services which are talk based might also do more to acknowledge the ways in which men do 'get through', sometimes with the help of other men. Whereas the literature has tended to focus on those methods that are dysfunctional (self-medication, avoidance techniques; Riska, 2009), other non-verbal ways of coping – being or doing alongside male friends – are also important. Talking might then best be seen as a complement to, rather than a displacement of, such forms of intimacy –

especially given the prevalence and persistence of beliefs among men about the non-efficacy of talk.

Spontaneity for men in raising emotional difficulties could also be exploited more effectively. If planning to talk is seen as emasculating, then the contingent nature of men's willingness to talk is best accommodated by those services that emphasise the unpremeditated and flexible nature of the support they offer. Important questions might be asked here about the implications of the new communications technologies for those who are entering their middle years and are relatively comfortable with such media.

Men clearly continue to value the confidentiality of support services and, at times, do seek support outside their personal networks, not least because it is those personal relationships that they need help with. Given the continuing stigma attached to seeking help for mental distress, however, and given the centrality of relationships to wellbeing, helpline organisations might want to think how they can use their contact time with men to encourage them to develop sustainable sources of support in their own lives and communities. In other words, although talk might be the medium for accessing support, working with men on developing their own support networks (not all of which will be talk based) or helping them identify other non-talk-based ways of managing distress might be more effective, and might be perceived by men as being so.

It is also worth remembering that the clearest predictor of use of formal emotional support remains need, whether defined in terms of lower levels of 'wellbeing' or of actual experience of serious mental health difficulties. Yet, despite the fact that poorer people are more likely to experience serious mental ill-health and lower subjective wellbeing, they remain relatively much more likely to be offered drugs than other forms of support. Attempts to shift such patterns – through addressing both demand and supply for such forms of intervention – must therefore remain a priority.

Similarly, while much can be done to encourage a different response from men in the face of emotional difficulties, it needs to be remembered that the root causes of many of those vulnerabilities – particularly for men from lower socio-economic groups – can only be tackled at state level. Support services need to be aware of the complex bundle of life-stage, demographic, relational and socio-cultural factors that interact with economic determinants to make mid-life a potentially vulnerable time, while at the same time beginning to recognise that mid-life is – or could be – an important opportunity for supportive intervention.

Endnotes

1. Claire Thain, Doctoral student in the School of Applied Social Science, at the University of Stirling, carried out literature searches for the report during the period February to April 2012. Key databases consulted were: Proquest Sociological Abstracts; Thomson Reuter Web of Knowledge; Proquest International Bibliography of the Social Sciences. In addition, in-journal searches were carried out of all relevant major social science journals using keywords. The majority of these journals were UK or North American based. The report also draws extensively on findings from a recent ESRC-funded UK population-based study of emotional support (The Someone to Talk to Study [RES-062-23-0468]) for which this report's author was Principal Investigator.
2. As Jamieson et al. (2009) note, there is an analytical need to separate 'solo living', 'singles' and 'solos', in order to distinguish between the categories of residence arrangements, legal marital status and partnership status. In other words, we need to avoid making assumptions about marital or partnership status from the fact that people live alone.
3. Even if the nature of this connection is still open to some debate (Platt, 2011).
4. Another explanation for high rates of suicide in the middle-age groups of those from lower socio-economic classes – the 'social drift' hypothesis – notes that chronic mental illness, including alcohol abuse which escalates over time, also culminates in mid-life (Kreitman et al., 1991). This reflects broader research evidence suggesting that suicide among men from lower socio-economic groups is often part of a complex array of difficulties (see Chandler, 2012, in this report).
5. Mapping such patterns is, in any case, methodologically complex, not just because class position may vary before, during and after partnering, but because data about men's relationship with their children, at least in some surveys, are less comprehensive than for women. Thanks to Graham Crow, University of Southhampton, and Kevin Ralston, University of Stirling, for pointing out these issues.
6. Understanding Society is the UK Household Longitudinal Study. It aims to collect data at annual intervals from all adult members of around 40,000 households, as well as from young people aged 10–15.
7. Thank you to the Scottish Centre for Social Research for carrying out this analysis.
8. The Someone to Talk To Study (STTT) was a mixed-methods study anchored around two main components: a 40-item module of questions included in the British Social Attitudes (BSA) survey (an annual study run by the National Centre for Social Research), and a series of qualitative follow-up interviews (52) with a sub-sample of survey participants, purposively selected to ensure diversity of demographic characteristics, attitudes and experiences. The BSA is based on a representative sample of the adult (18+) population in England, Scotland and Wales.

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Exploring the role of masculinities in suicidal behaviour

by Amy Chandler

Abstract

Masculinity is frequently cited as a potential reason why men are more likely than women to complete suicide. There has been less work exploring *why* this may be the case, and in particular, why men in certain social positions seem more vulnerable to suicide. In this paper I review a broad range of social scientific literature in order to elaborate upon and contextualise the suggestion that masculine identities and expressions contribute to men's greater propensity for completing suicide. I do this in two ways. First, I examine the situated nature of masculinities, particularly in terms of socio-economic context. I introduce research which has identified the different ways in which masculinities are expressed through employment, unemployment and fatherhood. This section demonstrates that, for men in lower socio-economic groups, opportunities for masculine expression may be constrained by both opportunity and socio-cultural expectations. This heightens the chance that men in such positions have of 'failing' to achieve an acceptable masculinity. I then turn to the ways in which masculinities are expressed through bodily means, elaborating on the claim that many masculine practices 'damage bodies'. I examine some of these practices, including fighting, health-related behaviours, and alcohol and drug use. Additionally, I address the claim that masculinity is especially associated with physicality. I problematise this, while suggesting that cultural expectations of masculinities do appear frequently to incorporate an approach towards bodies which is 'risky'. Leading from this I discuss some of the ways in which suicide itself could be understood as an especially damaging physical expression of masculinity.

Introduction

This report focuses and builds upon work on 'suicidal masculinities' (Canetto & Cleary, 2012; Scourfield, 2005) in order to contribute to socio-cultural explanations of the higher suicide risk among men of lower socio-economic status in middle age. I begin by introducing social scientific research on masculinities. The report then goes on to explore a variety of ways in which masculinities might contribute to suicidal behaviour.

In Section 1 I examine the claim that suicide might be related to the 'failure' of hegemonic masculinity (Scourfield, 2005). In particular, I review research which has discussed expressions of masculinity through (a) employment and unemployment, and (b) fatherhood. I suggest that men in middle age who are economically disadvantaged might be more susceptible to 'failures' of hegemonic masculinity, and that this provides a context whereby suicide is more likely. This discussion draws upon, and lends support to, work by Fincham and colleagues (2011).

Whereas Section 1 illustrates some of the contexts in which suicidal behaviour might occur, Section 2 attempts to answer the question of why suicidal behaviour (rather than other expressions of distress) might be used by men in response to these contexts. I situate suicide among a range of 'unhealthy practices' in which men are more likely to engage (Courtenay, 2000). Special attention is paid to substance misuse, as this is an important risk factor in suicide (Cleary, 2012; Stack, 2000) and is also found more frequently in contexts of socio-economic deprivation. I discuss the ways in which drug and alcohol use, socio-economic context and life stage might contribute to the unique

vulnerability of this group of men to suicide. Research into masculinities remains important throughout this section, and I suggest that suicide might be one of a number of ways in which men 'express' a masculine identity. In particular, I highlight the physical nature of these activities.

The research I draw upon is largely qualitative in nature. I am interested in demonstrating the ways in which society can impact on the individual experiences and understandings of men. Therefore, I examine research that seeks to understand why unemployment might lead to suicide; what might be the relationship between drug and alcohol use and completed suicide; and how changes in the labour market might particularly affect the lives and feelings of individual men in lower socio-economic groups and in mid-life. Qualitative approaches are extremely important to understanding suicide and suicidal behaviour, helping to explain why the patterns and trends identified by quantitative research occur. However, with some notable exceptions (Fincham et al., 2011; Owens et al., 2008), qualitative studies are rare in suicidology. Therefore, in this paper I draw widely on relevant research from sociology.

The approach used to identify literature was not systematic, but aimed at locating articles that reported on detailed qualitative research that helped to explain or illustrate why men in mid-life, from lower socio-economic backgrounds, are more likely to complete suicide. Following Scourfield's (2005) suggestion that masculinity might be a key source of such explanations, I chose to use this as a starting point. Literature was identified initially by conducting keyword searches in social science databases (e.g. ASSIA, IBSS, Web of Knowledge). Keywords used included suicide AND masculin*AND alcohol, embodiment, bodies, drug use, substance use, social class. References cited in the identified literature were also examined for relevant papers.

Masculinities

While 'masculinity' is a widely used term, within the social sciences it has been extensively debated and discussed (Connell, 2002; Connell & Messerschmidt, 2005; MacInnes, 1998; West & Zimmerman, 1987). Social scientific literature and research tend to accept that masculinity does not automatically follow from being 'male'. It has long been noted that being male or female does not preclude a person from acting in either a masculine or feminine way, or being successful in roles that are deemed either masculine or feminine (West & Zimmerman, 1987). Feminist research in particular has made strong claims that masculinity and femininity are not based primarily on biological differences between men and women (Birke, 2000). Rather, masculinity and femininity can be related to the way society organises itself around a view that men and women are different, have different roles and occupations, and consequently should act in different ways. However, in the wider public imagination (Banyard, 2011; Walter, 2010), the differences between men and women are routinely associated with biological sex, and in many academic disciplines debates about the biological basis of 'sex differences' are ongoing (see, for instance, Fine, 2010 on the extent and influence of such debates in neuroscience).

From a social scientific perspective, masculinity and femininity are understood to be the collection of roles, behaviours, activities, expressions and practices that are broadly associated with being, respectively, male and female. Frequently, these tend to be oppositional. For instance, masculinity is associated with strength, femininity with weakness; masculinity is aggressive, femininity is passive; a masculine person might be more physical, a feminine person more emotional. The oppositional nature of these classifications is, rightly, contested. However, such dualistic models of thinking about gender are widespread and pervasive (Connell, 2002; Williams & Bendelow, 1998). Further, while most people accept that these traits are not mutually exclusive and can readily be found among both men and women, it remains the case that, as regards gender role expectations, these oppositions tend to persist.

Social science now tends to use the terms masculinities and femininities. These terms attempt to acknowledge that, although there are often broad commonalities, what is understood to be 'masculine' or 'feminine' varies (sometimes significantly) across different social settings. Thus, younger men may

express, perform or practise masculinity in a different way from older men. Men and women from different ethnic or religious groups might practise masculinity and femininity in different ways. Individuals perform a number of roles and identities (e.g. father, builder, son, heterosexual, working class etc.), each of which may affect the way they express their gender identity (masculinity or femininity). To add another layer, the way that masculinity and femininity are expressed or practised varies according to social context. For example, the broadly 'masculine' practice of being dominant may be expressed differently across various social locations, such as, for example, a school, office, court room, shop, on the street, in a public house or bar.

Despite the complex nature of gender and gender identity, much work on gender and suicide has taken a relatively straightforward approach in order to explain the different rates of suicide among men and women (Payne et al., 2008). In more recent research, however, this is beginning to change (Canetto & Cleary, 2012; Cleary, 2012; Scourfield, 2005; Scourfield et al., 2012). In particular, the increased use of qualitative approaches to understanding suicide among men has enabled a more nuanced perspective, which takes greater account of the different ways in which masculinity is expressed, and how these different expressions might influence the variations in rates of suicide among men in diverse social groups.

Section 1: (Un)employment, fatherhood and suicide

(Un)employment and the failure of 'hegemonic masculinity'

Scourfield (2005) briefly suggests that some suicides may be related to the 'failure' of hegemonic masculinity. Hegemonic masculinity is a social scientific concept which refers to the current form of masculinity held in the highest regard in a particular social context (Connell & Messerschmidt, 2005). While the term has been subject to a great deal of debate, it is generally accepted that 'hegemonic masculinity' does not refer to the type of masculinity expressed or practised by most men. Instead, it should be seen as an ideal to which most men aspire or against which they measure themselves. In addition, 'hegemonic masculinity' is not fixed, and is understood to vary across different contexts. Therefore, the type of masculinity most valued will be different across, for instance, various national or socio-economic settings.

One important aspect of 'hegemonic masculinity' in the UK, across a range of contexts, is employment, both in terms of 'having a job' and also through the nature of the job itself (Dolan, 2011; Fletcher, 2010; Nixon, 2006; Payne et al., 2008). A variety of expressions and practices of masculinity are closely tied up with employment. For instance, masculinity is associated with independence and self-sufficiency, and also, where men have a partner or children, with the role of 'provider' (Braun et al., 2011). The type of job can also contribute to a man's practice of masculinity. This has important implications for men in lower socio-economic groups who, because of changes in the labour market, may have less access to jobs that allow for the expression of particular, situated expressions of working-class masculinity (Fletcher, 2010; Nayak, 2006; Nixon, 2006). Gender identities continue to be related to employment, despite women's far greater involvement in the workforce. At a basic level, gender stratification is still evident in employment patterns (Webb, 2010): for instance, it remains the case that most primary school teachers are women; most fire-fighters and builders are men; more women are nurses; and so on.

Statistically, the link between unemployment and suicide is well established (Platt, 2011), and Scourfield (2005) suggests that the relationship between 'hegemonic masculinity' and unemployment may be especially important in explaining suicide. The way in which unemployment might contribute to suicide is likely to be complex. As discussed further in Section 2, men who are unemployed or otherwise economically disadvantaged are more likely to engage in problematic alcohol and drug use, which is also a risk factor in completed suicide (Cleary, 2012). However, it is possible that other factors associated with the relationship between masculinity and

unemployment contribute to the particular vulnerability to suicide found among men in mid-life from economically deprived backgrounds.
The impact of life stage may be significant in this respect, since it has been suggested that men in their middle years are especially invested in work or employment as a way of constructing a masculine identity (Evans et al., 2011, p. 12). This might indicate that for men in this age group the loss of work, or even problems at work, may be particularly difficult. Fincham et al. (2011) discuss this at length in their analysis of coroners' case files of completed suicides. They suggest that problems associated with relationships and employment during the middle years are experienced keenly, because this is a stage of life more usually associated with stability and security. For instance, the loss of a job in early adulthood is viewed less seriously as there is plenty time to retrain, or even to build a different career. In contrast, for people in mid-life this is perceived as less possible.

Further, men who are unemployed lack an important source of a 'valued' masculine identity, and therefore may be at greater risk of a variety of other risk factors for suicide, including depression, social isolation, alcohol and drug use. In addition, it might be suggested that the economic stresses of being unemployed might contribute to suicidal behaviour among men – though the extent of this will be mediated by wider social process such as welfare provision (Lundin & Hemmingsson, 2009). As discussed in detail by Platt (2011), the relationship between unemployment and suicide is closely related to socio-economic deprivation (at both area and individual levels). In the following sub-section I explore in more detail how socio-economic deprivation and unemployment might contribute to higher rates of suicide among men in mid-life who are living in these contexts.

The 'feminisation' of employment?

Some authors have suggested that changes in the nature of employment and the labour market have had a particularly detrimental effect upon men, and may help to explain men's higher rates of suicide (Möller-Leimkühler, 2003). This may be particularly relevant to explanations for suicide among working-class men in specific geographical locations (e.g. post-industrial cities such as Glasgow, or in northern England). It is argued that men who would traditionally have entered manual trades no longer have access to such jobs; at the same time they lack the educational and identity resources to get jobs in the new 'feminised' (or service-oriented) economy (Nixon, 2006). Nixon suggests that such men continue to seek work in the now declining manual trades, leaving themselves open to a greater risk of unemployment. Nixon's work specifically associates this stance towards employment with working-class masculinities, indicating that working-class men have a particular, situated masculinity which means that having 'any job' is not sufficient; rather, the job has to be one that involves a particular form of masculine expression (see also McDowell, 2000). Low-skilled unemployed men of all ages constructed a clear and consistent dichotomy between the jobs they sought and defined as 'good' and those they rejected as a potential route out of unemployment. Generally, and across all ages, 'good' jobs were those that required manual skills and took place in male-dominated 'back-shop' environments (Nixon, 2006, p. 214).

The qualitative research conducted by Nixon and McDowell gives an explanation for the higher risk of unemployment among economically disadvantaged men who are low-skilled and have poor education. Not only are they less eligible for many jobs in an increasingly technological, skills-based economy, they are also unwilling to undertake low-skilled jobs in the service industries. Nixon suggests that they are unable to 'reconstruct' their identity to fit the changing nature of the employment market. Given the relationship between suicide and unemployment, such research may at least partly explain the higher rates of suicide found among men in 'post-industrial' cities such as Glasgow, Belfast and the north of England.

Although the above is certainly not a straightforward 'cause' of suicide, it needs to be understood as a part of the broader context of economically disadvantaged men's lives. This is not simply a situation of economic deprivation, but one where a sense of masculine 'self' is particularly endangered.

Importantly, the qualitative research I have reviewed indicates a lack of viable options open to some men, in terms of both employment (Nixon, 2006; Nixon, 2009) and their role in the family as fathers, of which more below (Braun et al., 2011). When various other aspects of life might be 'falling apart' (Shiner et al., 2009), such a context might be seen as offering little comfort in terms of reasons not to attempt or complete suicide.

Fatherhood and masculinity

One of the explanations for women's lesser vulnerability to completing suicide is their greater involvement in child-rearing, and the relatively higher importance placed at societal and individual levels on their role as a 'mother' (Appleby, 1991). This is contrasted with an implied suggestion that men are less invested in the role of being a 'father', or that this role is less protective for men than the role of 'mother' is for women. The nature of parental roles, expectations and aspirations is closely tied with wider gender relations. Additionally, there are indications that the expressions and enactments of these roles vary according to socio-economic class (Shows & Gerstel, 2009; Sullivan, 2010).

Along with women's greater involvement in paid employment (notwithstanding the qualifications discussed below) has come an increased expectation that men will be more 'involved fathers' (Braun et al., 2011). This is a complex issue, particularly when socio-economic differences are examined. How 'involved' fatherhood is expressed varies according to socio-economic context, and this can be related to resources of both time and money. For instance, a US study examined the ways in which employment patterns affected expressions and practices of fatherhood (Shows & Gerstel, 2009). They found that men (physicians) who worked in highly paid but time-intensive roles engaged in 'public fathering' – where they provided financial support to their families and paid for extra-curricular activities, but spent little time with their children. Conversely, men working in much lower-paid jobs (as emergency medical technicians) were more likely to engage in 'private fathering', where they were much more involved in day-to-day care of children. This could be related to the fact that they and their partners worked different shift patterns, which forced a more egalitarian orientation towards care of children.

However, in contrast to the above, research by Braun and colleagues in the UK suggests a more complex picture (Braun et al., 2011). Their study involved a broader range of men and families in different professions, including men who were unemployed. They found that some men who were unemployed, and thus had a great deal of 'spare' time, remained uninvolved in child care. Braun et al. argued that in the UK, understandings about fatherhood among men were still strongly associated with 'providing' economically for the family, rather than involvement in practical or day-to-day care of children. Thus, even in cases where men were more involved in child care (including some cases where women worked full-time and men were unemployed), the way this was described by the parents continued to draw on more 'traditional' conceptualisations of masculinity and femininity.

In spite of these men being 'active', highly involved fathers, they were at times uncomfortably aware that they had to negotiate the question of how to be a father while not being the main provider:

'It's probably like a guy thing, I do sometimes feel like I should be going out and earning, putting some bread on the table' (Braun et al., 2011, p. 25, quoting an unemployed father).

What is potentially important in the above quote, and is reflected in other research on masculinity and employment, is the discomfort experienced by men when performing 'non-masculine' roles. For example, unemployed men interviewed by Dolan reported extreme anxiety around their 'failure' to provide for their families: 'It's difficult to keep your self-respect if you can't provide for the family' (Dolan, 2011, p. 590).

Despite the well-documented decline of the 'male breadwinner system' (MacInnes, 1998), in the UK it remains the case that (most) men are expected to work, and in the vast majority of cases to fulfil the role of primary earner in families. Particularly after the birth of children, women are far more likely to

either stop paid employment (permanently or temporarily) or to work part-time (Fouarge et al., 2010). This may be especially important to the association between unemployment and suicide discussed above. For men in mid-life, who are more likely to have family responsibilities, unemployment might represent a particular 'failure' of the masculine role. For such men, unemployment may in fact represent a double failure: they no longer have a masculine role in terms of being employed; and they may feel they have failed in terms of their role as father or husband in 'providing' for the family (Dolan, 2011). This may partly explain why employment status is more closely associated with male than female rates of suicide (Payne et al., 2008).

Fincham et al. (2011), in their analysis of 100 completed suicides, provide further elaboration of the relationship between suicidality, masculinity and fatherhood. They found that a significant number of the male suicides they examined could be related to relationship breakdown and subsequent separation from children. Because of both legal and social constraints, following the break-up of relationships men are more likely to have limited, or even no, contact with children. This circumstance jars, however, with the increasing expectation that men should be more involved in children's lives. Fincham et al. suggest that, in these cases, men may experience yet another 'failure' of an ascendant form of hegemonic masculinity, which entails involved fathering. Taken alongside the above discussion, this indicates the narrow and constraining nature of hegemonic masculinity. Even where alternative forms of masculinity are emerging, men who are frustrated in their attempts to take on appropriately masculine roles may be vulnerable to a range of problems, including suicide. This is not to suggest that femininity is any less constraining; rather, it is to highlight the potentially damaging effects of societies and cultures organised around oppositional and exclusive gender identities, particularly for people occupying disempowered social positions (see, for instance, Coston & Kimmel, 2012 for further discussion of disempowerment and masculinity).

The complex relationship between men's age, status as a father, socio-economic class and employment status may partly explain some men's propensity towards suicide. While research has suggested that, for some men, fatherhood can be experienced as a protective factor against suicide (Oliffe et al., 2011), this is certainly not the case for all fathers. For some men, the combination of unemployment, mid-life, fatherhood, and a socio-cultural context which maintains that the only way to be an adequate father is to 'provide' (Braun et al., 2011), may increase the likelihood of suicide. Evidently, most men in these situations do not complete, or even attempt, suicide. However, the above is a useful further addition to the research on the relationship between masculinity and suicide.

Section 2: Suicide, and other bodily expressions of masculinity

Bodies and masculinity

This section builds upon a broad 'turn' within the social sciences towards the importance of bodies in social life (Crossley, 2006; Turner, 1984). I consider this in several ways, beginning with a brief examination of the ways in which bodies are implicated in expressions of masculinity, particularly relating to health. Social scientific work on bodies has highlighted the importance of physical, visible bodies in expressing aspects of social identity. Bodies are prime sites for signifying or performing gender identities. For instance, hegemonic masculinity (introduced above) might be enacted through building muscles, dressing or walking in particular ways, or having certain hairstyles. This contributes to the theory that, in the late 20th and early 21st centuries, bodies are becoming increasingly important as sites of identity creation and maintenance (Budgeon, 2003; Giddens, 1991). This theoretical approach may be particularly significant with regard to suicide, which involves effectively ending the 'self' through a range of fatal bodily practices.

Many of the ways in which masculinity is expressed or performed are said to be particularly physical, closely involving 'the body' (Jefferson, 1998; Robertson, 2006). However, physicality and 'the body' are more often associated with people occupying disadvantaged social positions, usually women (Connell, 2002). That said, and as this report emphasises, many men also occupy disadvantaged social positions; thus it is important to take into account the intersection between masculinity, social class, race/ethnicity, age, dis/ability and sexuality (Robertson, 2006). For instance, some have suggested that the bodies of men in advantaged positions 'disappear', whereas for 'other' men bodies are more central to identity creation and maintenance (Morgan 2002 in Hall et al., 2007, pp. 539–540). Morgan, along with Hall et al., urges caution in the attribution of 'disembodiment' to particular social groups, suggesting that this is not only empirically incorrect, but may contribute to the privileging of those in certain social positions. Indeed, the idea that some people are more 'bodily' than others has uncomfortable parallels with historical attempts to associate marginalised groups with 'nature' and 'animals', reifying a white, male, economically advantaged position and de-humanising 'others' (Bordo, 1993).

A significant argument, highlighted by Scourfield in his paper on suicidal masculinities, is that many of the bodily practices associated with masculinity actually 'damage bodies' (Connell, 2000, in Scourfield, 2005, 3.1). Importantly, many of these 'damaging' masculine bodily practices can be more closely associated with men in lower socio-economic groups: fighting, and excessive drug and alcohol consumption in particular (Dolan, 2011; Mac an Ghaill & Haywood, 2011; Nayak, 2006). More implicitly, these damaging health practices include not presenting quickly with medical concerns, or downplaying problematic physical symptoms (Courtenay, 2000; Dolan, 2011; Gough, 2006).

'I think men have got to be tougher. They don't want to be a sissy going to the Doctor all the time… Hypochondria is something you would associate with a woman… And women, well they have their troubles. They have got more complicated bits… In a way it's all right for a woman to admit that she is physically failing, somehow it is easier in a way. But for a man to say he is having physical problems… it's just not as easy' (male, aged 28 in Dolan, 2011, p.595).

Dolan's research examined the ways in which men in less affluent areas described and accounted for their health. As illustrated in the quote above, masculinity was associated with an approach towards the body which emphasised strength and minimised physical problems. This orientation towards the body was also evident in the men's discussions of taking physical risks at work. Dolan argues that the structural conditions of economically deprived men's lives contributed to their being forced to take a 'cavalier' attitude towards their health and bodies. Dolan's work carefully demonstrates the ways in which men's expressions and enactments of valued (hegemonic) masculinity can be related to the socio-economic conditions in which they live.

Masculinities, then, are understood to be closely related to a variety of physical, bodily concerns. This includes engaging in a greater range of 'risky' bodily practices, having a 'cavalier' attitude towards bodily health, and avoiding help-seeking. In addition, and relating to the discussion above on employment, the types of jobs viewed as 'masculine' in many contexts are often those that are particularly physical, or even dangerous, including manual trades such as building, fire-fighting and the military (Nixon, 2006).

Drinking, drug use, and suicide

Alcohol and drug use are perhaps the most widely discussed damaging bodily practices, associated closely with both suicide and being male (Boenisch et al., 2010). Both are also statistically related to unemployment (Henkel, 2011) and lower socio-economic status (Grittner et al., 2012), and therefore of great importance to the aims of this report. Excessive alcohol use is found among men across different social classes (Harrison & Gardiner, 1999); however, alcohol-related harm, for instance alcoholic liver disease, appears to be more common among people from lower socio-economic backgrounds (Erskine et al., 2010; Hart et al., 2009). The reasons for this are unclear, although both

patterns of alcohol use (e.g. binge drinking) and living in areas of socio-economic deprivation appear to contribute (Mäkelä et al., 2003; Rehm et al., 2004).

The relationship between gender, social class, substance use and suicide is complex, and a detailed examination is not possible in the context of this report. Instead, this section will explore alcohol and drug use as embodied practices, exploring the extent to which a focus on bodily aspects of substance use and suicide might contribute to explaining male suicide. This analysis is particularly relevant given that men in mid-life, from lower socio-economic backgrounds, appear to be more susceptible to both substance-related harm and suicide.

It is proposed that certain patterns of drinking and drug use are used to express different forms of masculinity (Holloway et al., 2009). In particular, Nayak (2006) suggests that drinking styles can be seen as embodied performances and enactments of social class. Nayak's research was carried out in the North East of England, and he argued that, for (young) men in this post-industrial context, public consumption of alcohol had become a way to express a 'working-class' masculinity that was otherwise difficult to embody given the decline of 'traditional' industry.

Despite changes to the manufacturing base, the real Geordies maintain 'felt' investments in the traditional basis of working class culture. The spirit of white masculine excess is very much alive in their nostalgic affection for the region: the emphasis on male drinking pursuits […] Body-reflexive practices such as 'getting' mortal' (drunk) […] playing and watching football and, somewhat predictably, 'shaggin'' were a means of signifying masculine prowess beyond the workplace (Nayak, 2006, p. 820).

While Nayak's work focused on younger men, the association between working-class masculinity and alcohol use is more widely relevant. What it indicates is that, for men across the life course, alcohol use is an important part of everyday life and a potentially integral aspect of masculine expression. This is one example of the ways in which bodies are used by individuals to express or perform social identities.

The association between masculinity and alcohol and drug use has led to the suggestion that men are more likely to 'self-medicate' using such substances (Cleary, 2012). This relates to the view that men avoid 'help-seeking' and instead attempt to 'cope' with problems in other, non-verbal ways (see also Julie Brownlie's report). For instance, respondents in Dolan's (2011) research on working-class masculinity and health practices reported using alcohol as a way of managing emotions: 'It can be a lot more than just going out getting pissed and having a laugh. It can be a release… A very big release… You've had a stressful time at work and it acts as a release valve' (male, aged 34, in Dolan, 2011, p. 597).

Other respondents, in more difficult socio-economic circumstances, described using drugs or alcohol as a way of 'escaping' from life: 'You kind of feel shit that you've got no job… no money, so you try to look for an escape from that' (28-year-old male in Dolan, 2011, p. 598). The research by Dolan with men – where the focus was not depression, self-harm or suicide – illustrates that men might be more likely to use drugs or alcohol to 'cope with' problems. Work by Green and colleagues with ex-army personnel also highlighted the excessive use of alcohol as a 'normalised response to emotional distress' (Green et al., 2010, p. 1484). This is further supported by qualitative research by Oliffe and colleagues (2012) and Cleary (2012), which found that men who were either depressed or who had engaged in 'suicidal' self-harm reported using alcohol or drugs as a way of attempting to manage or cope with depression: 'I wasn't being up to standard. I started looking at ways out with drugs and alcohol giving me a temporary way out and eventually coming back there was, there was always suicidal thoughts' (44-year-old unemployed male, in Oliffe et al., 2012, p. 511). Thus, alcohol and drug use is said to be a 'masculine' way of coping, in contrast to more 'feminine' methods, such as seeking help or talking to people.

Another way in which alcohol and drug use might contribute to suicidal behaviour is via their impact

on increasing impulsivity and reducing inhibitions (Cleary, 2012; Möller-Leimkühler, 2003). This may well be a contributing factor. Both self-harm and completed suicide are related to alcohol use. Alcohol may serve to reduce inhibitions, making self-harm more likely, or enabling more severe (and more life-threatening) self-harm than might otherwise have been possible (Pompili et al., 2010).

The relationship between alcohol and drug use and suicide is complicated. Alcohol and drug use are associated with a wide range of social problems (including unemployment, relationship problems, psychological problems), each of which may also make suicidal behaviour more likely. Conversely, alcohol or drug use may exacerbate such problems. As discussed above, some research suggests that men in particular use alcohol and drugs as a way of attempting to cope with problems (Cleary, 2012). Unpicking the relationships between social class, life stage, drug and alcohol use and suicidal behaviour is an ongoing challenge. What I have suggested here, following Cleary (2012), is an additional perspective, suggesting that suicide, alcohol and drug use could be viewed as embodied, (mal)adaptive 'coping strategies' . In the following section I explore this idea further.

Masculinity as a driver in suicidal behaviour

Along with greater use of alcohol and drugs, it is suggested that men use other forms of physical, non-verbal methods of dealing with distress. For instance, research has examined the way that fighting is used by some men in response to bullying. Green and colleagues' research with ex-military personnel identified a complex and ambiguous set of relationships between aggression, social bonds and mental health. Here they discuss the account of a man who had been bullied, and who responded to this by learning to fight; significantly, he did this rather than 'seeking help':

'He explained that his lack of maturity and toughness resulted in him being badly bullied, but he did not report this to his commanding officers because he 'was trying to be a man'. Eventually, he joined the boxing squad to become 'hard' and explained that when he 'actually got a set of balls' his former tormenters became 'like my best mates'' (2010, p. 1483).

This is a useful discussion, linking hegemonic masculine ideals of 'hardness' with an aversion to help-seeking and a corresponding investment in a particularly physical alternative response (boxing). Interesting parallels are found in Jefferson's (1998) analysis of Mike Tyson's life story, where he argues that Tyson (like the man above) turned to fighting and boxing in response to bullying. Jefferson similarly highlighted the importance of 'hardness'; however, he suggested that this was not a straightforwardly physical concept. Rather, 'hardness' was embodied, and incorporated both physical and mental attributes. In particular, mental hardness entailed a 'willingness to risk the body in performance' (1998, p. 87). The association of 'hardness' with risk and the body has parallels with the discussion, above, of men's expression of masculinity through risky physical work (Dolan, 2011). This further extends the complex notion that bodies are central to expressions of masculinity, but that simultaneously expressions of masculinity frequently seem to celebrate taking risks and endangering the body – in some cases framing this as 'heroic'.

The association between masculinity and taking risks with the body is important to the suggestion that 'some aspects of hegemonic masculinity could be health-damaging, and even push men towards contemplating suicidal behaviour' (Emslie et al., 2006, p. 2255). This is a strong claim, but similar arguments are made elsewhere (Möller-Leimkühler, 2003; Oliffe et al., 2012). Emslie and colleagues' research on depression among men indicates that 'hegemonic masculinity' is associated with emotional control and power. In contrast, depression is linked with powerlessness and a lack of control over emotions. Thus, in some of the accounts analysed by Emslie et al., suicide was described as a way of expressing or regaining control in the face of depression:

'I realised that something was out of control […] I found myself standing at the top of a tower block

thinking 'this doesn't work, I've had enough, I want to stop' […] I don't know why I didn't actually jump off, I just didn't. And came home with just a different level of seething resentment and hatred which actually made me feel very powerful because I realised I'd gone through something' (Emslie et al. 2006, p. 2252).

'I hear people talking about suicide, it was a cry for help, it was, you know, it was cowardice or whatever. No – it was a positive step. It's the best thing that you feel that you can possibly do at the time' (ibid).

Emslie and colleagues suggest that, for some men, suicide is incorporated into a version of an 'in control' masculine identity. This is also present in a respondent in Oliffe et al.'s research who said: 'If I want to commit suicide, I just do that. I don't call someone and say "OK shall I do that or not?"' (2012, p. 512). The view expressed in this quotation poses a challenge for those working in suicide prevention.

A final way in which masculinity is directly associated with suicide relates to men's use of more 'lethal' methods in suicide attempts. Again, this argument directly implicates and involves the body, though this is not often emphasised. Men's greater use of more lethal methods in acts of self-harm has been linked to their beliefs about appropriate masculine behaviour. The use of more 'lethal' methods is seen as incorporating and embodying 'masculinity' (Hawton, 2000). Further, it is argued that men are more likely to choose more 'lethal' methods in order to ensure that they complete suicide and do not have to suffer the additional shame of simultaneously 'failing' to complete suicide and being associated with the more 'feminine' practice of self-harm (Canetto & Sakinofsky, 1998). Oliffe et al. (2012, p. 512) affirmed this view in their research on men with depression who had self-harmed, saying 'it was clear that lethal suicidal behaviours were perceived and affirmed as masculine terrain, whereas nonfatal suicidal behaviours had negative gender connotations for many men'.

Section 3: Conclusions and implications for policy and practice

Conclusions

The literature reviewed above has presented a broad analysis of the ways in which masculinities might contribute to suicidal behaviour. I have attempted to qualify this where possible with a focus upon the particular experiences of men in mid-life, in economically disadvantaged contexts.
An examination of research on employment and fatherhood demonstrated the ways in which these comprise key resources through which men can express or perform a masculine identity. I have suggested that for men in mid-life who are economically disadvantaged, these roles may be particularly restrictive. Men in such social positions are less likely to have alternative means of expressing or 'achieving' a masculine identity (West & Zimmerman, 1987); and the types of masculinity deemed 'acceptable' in such contexts are limited. Additionally, the chances of such men 'failing' in their attempts to 'achieve' an acceptable masculine identity are heightened by socio-economic and educational constraints. This indicates the importance of socio-cultural context in explaining the vulnerability of certain men both to suicide and to other expressions of distress, such as alcohol and drug use.

I went on to explore potential reasons why suicide in particular might be the response of men in this group to such vulnerability. This discussion focused upon the importance of bodies and physicality, demonstrating the problematic relationship between masculinities and 'the body'. Leading from this, I highlighted the high use of alcohol and drugs among men, and drew attention to the complex relationship between substance misuse, socio-economic context and suicide. I presented an examination of the bodily nature of men's normative responses to distress: substance misuse, fighting, suicide, while noting that these more damaging bodily responses appear to be more closely associated with men in lower socio-economic

positions. I suggested that suicide might be one of a range of physical responses to distress, more likely to be carried out by men because of the socio-cultural association between masculinity and physicality. That men in lower socio-economic contexts appear to be particularly vulnerable to using their bodies to resolve distress might be explained by a number of factors, not least a lack of viable alternatives. Men who experience a lack of control over important areas of their lives (fatherhood, employment, relationships) may feel their body is one the one remaining means through which they are able to exert any form of control or mastery.

This report demonstrates the importance of understanding masculinities and the different, and situated, ways in which men express and perform masculinities in response to specific socio-economic contexts, in developing an explanation of why men of low socio-economic position are at excessive risk of suicide.

Encouraging men to use Samaritans' services

The literature reviewed above highlights the 'toxic' aspects of (especially) working-class masculinities, indicating that there is a great deal of scope to work towards making alternative or diverse forms of masculinities more acceptable or possible. However, it should be noted that these perspectives might be easier for more affluent men to embrace. Developing more positive masculine identities in the face of economic hardship, lack of skills, family breakdown and deeply entrenched images of 'strong and silent' masculinity may be more difficult. The challenge is how to encourage alternative masculinities without alienating the men one aims to reach, and still communicating in a way that makes sense to them.

One approach might be to tap into existing aspects of masculinity to reach men and encourage positive behaviours. However, this needs to be done with care, because of the dangers of reinforcing 'problematic' aspects of masculinity or placing demands on men to conform. Oliffe et al. (2012) note that some of the men in their study on depression and suicide talked about 'fighting' suicidal tendencies, or 'not giving up on' life. These 'masculine' but nevertheless more life-affirming perspectives might be useful. However, reinforcing the association of 'strength' with masculinity may be problematic owing to the framing, in some instances, of suicide itself as a 'display of strength and control'. Relatedly, work by Emslie et al. (2006) found that some men disliked the connotations of dependence implied in treatment for depression: dependence on professionals or on antidepressant medication. A possible approach to improving the use of Samaritans' services could be to frame them as a way of maintaining independence. More broadly, help-seeking could be positioned as a way of maintaining independence; this could be done through reframing the discourse of help-seeking as 'dependence' into something more like what Oliffe et al. describe as 'connecting': taking control and using social networks in a 'rational, responsible' manner. Care would be needed not to further devalue dependence, and further, this approach (a) might inadvertently stigmatise those who engage in suicidal behaviour; and (b) may be less available to economically disadvantaged men.

Wider suggestions for policy and practice to reduce suicide in this group

It may be possible to look more closely at the relationship between parenthood and the risk of suicide. This would be a very broad approach, but if women are to a great extent protected against suicide when they have children (Hawton, 2000), and this is related to a greater investment in protecting and caring, perhaps more could be done to encourage this in men. This reflects much wider concerns regarding gender inequality and how this is exacerbated by child-rearing practices and attitudes towards child care and gender. These are issues which are supported by unequal maternity/paternity leave and continued institutional and ideological support of the role of the 'mother' through both employment law and, arguably, the courts in cases of separation.

Given men's greater involvement in bodily ways of 'coping', such as drug and alcohol use, as well as sport or physical activity (Robertson, 2006), a focus on 'talking' as a way of managing suicidal feelings may be problematic. Therefore, it is possible that encouraging men to become involved in team sports, or other non-talk focused, yet social, activities may be a positive move.

However, I am unsure how far a focus on sport inadvertently plays into unhealthy and unhelpful versions of masculinity. There have been a number of high-profile cases of sportsmen either dying by suicide (Gary Speed) or revealing problems with depression (Duncan Bell), demonstrating that involvement in sport itself is certainly not a guaranteed 'answer' to these issues. Indeed, the reporting of these sportsmen's troubles has been instructive. Bell, in particular, has been said to have only now 'admitted' his struggle with depression after 'years of silence'. In this way, reporting of the issue simultaneously valorises his silence while encouraging men to 'speak up' if they are suffering similar problems (Averis, 2012). Indeed, commentators have framed Bell as almost 'heroic' in having the 'strength' to stay silent for such a long time. I would suggest that such reporting should be challenged if there is to be any hope of its becoming more acceptable for men to talk about their problems, or to seek help at an earlier stage.

Another broad suggestion, aimed at preventing or discouraging suicidal feelings, would be local initiatives designed to prevent suicidal feelings. I realise this is quite a step away from Samaritans' focus on a person in crisis who needs support immediately, and would be oriented towards reducing levels of distress in communities. This leads from the literature reviewed above, which suggests that in particularly deprived socio-economic contexts there may be a combined lack of hope, vision of a suitable future, and opportunity. Thus, there is perhaps room for community-level initiatives directed particularly at men and encouraging positive activities, socialisation and interaction.

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Biographies

Professor Stephen Platt

Professor Stephen Platt is a Samaritans Trustee and has led the production of this report. Stephen is Professor of Health Policy Research at the University of Edinburgh. For 35 years he has pursued a research interest in mental health and suicidal behaviour, co-authoring many academic books and articles on socio-economic, epidemiological and cultural aspects of suicide and self-harm.

He has been particularly concerned with the influence of labour market conditions and related inequalities on the incidence of suicidal behaviour, and with the challenges of developing strategies and approaches to suicide prevention.

Stephen contributed to the development of *Choose Life, a National Strategy and Action Plan to Prevent Suicide in Scotland* and led a consortium of researchers who undertook a formative evaluation of the first phase of the strategy.

He is currently a member of the International Academy for Suicide Research and the Scottish Government National Suicide and Monitoring and Implementation Group, and serves on the Scientific Review Board for the American Foundation for Suicide Prevention. Stephen is also involved in policy development and analysis relating to public mental health and mental health improvement, and has extensive experience of successful collaboration with policy planners and practitioners working in these areas.

Clare Wyllie

Clare Wyllie is Head of Policy and Research at Samaritans. Prior to joining Samaritans she worked within the South African presidency, providing policy analysis and research on media and democratic participation. She worked for the South African Human Rights Commission, producing reports on progress in realising human rights. She has also worked for the NGO Agenda, editing a journal on gender in Africa and running a programme mentoring women writers. Her research interests are gender in policy, services and institutions, and 'lived experience', sociology of mental health, and the use of qualitative research to inform policy and practice.

Dr Julie Brownlie

Dr Julie Brownlie is a Senior Lecturer in Sociology at the University of Stirling and an Associate Director of the Centre for Families and Relationships based at The University of Edinburgh. She researches and publishes in the area of the sociology of childhood, families and relationships, sits on the Editorial Board of the journal, Sociology, and has recently completed, along with NatCen Social Research, an ESRC funded study on emotional support. Findings from her previous research, *The Someone To Talk To Study*, informed a range of service providers in the UK, including Samaritans.

Dr Amy Chandler

Dr Amy Chandler is a sociologist special-ising in mental health, particularly self-harm and suicide, health services research and qualitative, life-story methods. Her research is concerned with the following: the

importance of bodies to under-standing 'lived experience'; the impact of communication on mental health and family life; the ways in which embodied practices become medicalised; and how health related practices are negotiated in medical and other settings.

Amy's current research is on an NHS Lothian funded project, exploring under-standings about parenting capacity and parenting support among drug users and service providers.

Alongside this, Amy remains active in disseminating and developing work from her doctoral research on self-harm. The research comprised a sociological analysis of self-injury, with a focus on embodiment.

Sheelah Connolly

Sheelah Connolly is a Research Fellow at the Irish Centre for Social Gerontology at the National University of Ireland Galway (NUIG). She previously worked as a lecturer in Economics at NUIG and QUB, and a Research Fellow in the Centre for Public Health, QUB. She was a visiting researcher to the London School of Hygiene and Tropical Medicine in 2008.

Sheelah's research interests lie in the area of the social and socio-economic deter-minants of health and the economics of ageing. She has worked on a number of studies exploring the impact of area of residence on health status, including an assessment of area factors and suicide risk. Sheelah is currently involved in a number of projects examining the social and economic aspects of dementia.

Rhiannon Evans

Rhiannon Evans is a PhD student at the public health centre DECIPHer, Cardiff University. Her primary research interests include the social and emotional learning (SEL) of children and young people, and the evaluation of school based inter-ventions aimed to develop competency in this area. In particular she is interested in the lived experience of participating in SEL interventions, and how this experience is mediated by class and gender, notably constructions of masculinity.

Rhiannon is further interested in suicide prevention and intervention, and recently conducted the research for Mind Cymru's national evaluation of the roll out of Applied Suicide Intervention Skills Training (ASIST) in Wales.

Brendan Kennelly

Brendan Kennelly studied economics at University College, Cork and at the University of Maryland, College Park. He has been a lecturer in economics at NUI Galway since 1991.

Much of his recent research has been in the economics of mental health and suicide. He is the joint author of a major report on the Economics of Mental Health in Ireland for the Mental Health Commission. His papers on the economics of suicide and mental health have been published in journals such as Crisis, Health Policy, and the Irish Journal of Psychological Medicine. He is the joint author of a chapter on the economics of suicide in the Oxford Textbook of Suicidology that was published in 2009.

Olivia Kirtley

Olivia Kirtley is a Psychology PhD student in the Suicidal Behaviour Research Laboratory (SBRL) at the University of Stirling. Her current work looks at the psychophysiological correlates of self-harm and suicidal behaviour, specifically altered pain sensitivity.

Dr Graham Moore

Graham Moore is a Research Associate in the Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement (DECIPHer), School of Social Sciences, Cardiff University. His interests include the implementation, functioning and effectiveness of complex public health interventions. In particular, he is interested in understanding how intervention effects are differentiated by socioeconomic status, and thus the impact of interventions on health inequalities. The majority of Graham's work to date has centred around the evaluation of health improvement policies in Wales, including randomised trials of the Primary School Free Breakfast Initiative and the National Exercise Referral Scheme, and a repeated cross sectional study of changes in childhood second-hand smoke exposure after implementation of smoke free legislation. Graham is currently leading the development of guidance for process evaluations of complex public health interventions.

Professor Rory O'Connor

Rory O'Connor is Professor of Psychology at the University of Stirling, Honorary Professor at University of Nottingham, UK and President-Elect of the International Academy of Suicide Research. He is a registered health psychologist who is broadly interested in self-regulation and health outcomes.

Rory leads the Suicidal Behaviour Research Laboratory (SBRL) at Stirling, the leading suicide/self-harm research group in Scotland. He has published extensively in the field of suicide and self-harm, specifically concerning the psychological processes which precipitate suicidal behaviour and self-harm. He is also co-editor of the recently published International Handbook of Suicide Prevention: Research, Policy and Practice, with Steve Platt & Jacki Gordon; the forthcoming Routledge Major Works Collection on Suicide, with Keith Hawton; and co-author of Understanding Suicidal Behaviour with Noel Sheehy.

Rory is also the UK National Representative for the International Association for Suicide Prevention and a fellow of the International Academy of Suicide Research. He also serves on the Scientific Review Board of the American Foundation for Suicide Prevention and the editorial boards of Suicide and Life-Threatening Behaviour, Suicidology Online, Psychology and Health, and Journal of Behavioural Medicine.

Professor Jonathan Scourfield

Jonathan Scourfield is Professor of Social Work at Cardiff University, having formerly worked as a probation officer and secondary school teacher. Last year, Jonathan co-authored the book *Under-standing Suicide: A Sociological Autopsy*, based on research into 100 suicide cases from a coroner's office in the UK.

Jonathan's research interests cover children's identities and child welfare as well as suicide prevention. He has a long-standing interest in social work with men. His suicide-related research has touched on gender differences in suicidal behaviour, young people's help-seeking and young people's understanding of suicide and self-harm.

You can follow Professor Scourfield on twitter @ProfJScourfield

Someone to talk to – people contact us when things are getting to them. They don't have to be suicidal.

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