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Suicidal action, emotional expression, and the performance of masculinities

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ABSTRACT

Male rates of suicide are significantly higher than female rates in Ireland and other Western countries, yet the process and detail of men's suicidal action is relatively unknown. This is partly due to prevailing theoretical and methodological approaches. In this area of study, macro-level, quantitative approaches predominate; and theoretical frameworks tend to adopt unitary notions of men, as well as binary, oppositional, concepts of masculinity and femininity. This inquiry, based on in-depth interviews with 52 young Irish men who made a suicide attempt, examines suicidal behaviour at the individual level. The findings demonstrate that these men experienced high levels of emotional pain but had problems identifying symptoms and disclosing distress and this, along with the coping mechanisms used, was linked to a form of masculinity prevalent in their social environment. Dominant or hegemonic masculinity norms discouraged disclosure of emotional vulnerability, and participants used alcohol and drugs to cope – which exacerbated and prolonged their distress. Over time this led to a situation where they felt their options had narrowed, and suicidal action represented a way out of their difficulties. These men experienced significant, long-lasting, emotional pain but, in the context of lives lived in environments where prevailing constructions of masculinity constrained its expression, they opted for suicide rather than disclose distress and seek help. Underpinning this study is a presumption that binary notions of male and female emotions lack substance, but that the expression of emotions is gender-specific and constrained in some social localities.

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Introduction: the sociological study of suicide

Suicide, especially among young men, increased significantly in most Western countries in the latter decades of the twentieth century, a trend apparent in Ireland since the 1970s (NOSP, 2009). Yet, despite its public health importance, and its historical significance within sociology, there has been relatively little sociological interest in this topic over the last century. The study of suicide has become increasingly the domain of bio-medical disciplines. The sociological work which does exist has tended to follow Durkheim (1951 [1897]) in adopting a quantitative, macro-level, approach. This endeavour has produced some support for his thesis that integrated societies have lower rates of suicide. High levels of factors considered to promote social integration, such as participation in religion and close family ties still result in lower suicide rates, but other features identified by Durkheim, notably youth and poverty, no longer protect. There is now a consistent association between low socio-economic status and suicidal behaviour (Baudelot & Establet, 2008; Gunnell, Peters, Kammerling, & Brooks, 1995) and since the mid twentieth century younger, rather than older, people have been more likely to complete suicide (Middleton, Sterne, & Gunnell, 2006; World Health Organisation, 2011). These investigations provide a profile of suicide patterns in contemporary society (and a rationale for the particular focus of this paper), but they offer little insight into the process of suicidal action (Redley, 2003, 2009; Swami, Stanistreet, & Payne, 2008). In line with Durkheim's theory, a disconnection is maintained between societal factors and individual motivations. Over four decades ago, Douglas (1967) remarked that the meaningful analysis of suicide would have to be based on the definitions supplied by the social actors involved, yet few studies have attempted this. An exception is Redley's (2003) work, which illustrates why individuals in particular environments may opt for suicidal behaviour. However, no qualitative study of suicide has focused specifically on young men – the group who are most at risk. The present enquiry seeks to address this gap in the sociological literature by examining the emotions and meanings involved in suicidal behaviour, based on a sample of young men who made a suicide attempt. In seeking to understand why these men moved towards suicidal decisions, I draw on concepts and knowledge from gender and masculinity studies relating to men's emotional lives and health-related practices.

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Masculinities, emotions, health behaviours and suicide

The gender pattern in suicide – a significant excess of males over females – has remained consistent since the nineteenth century, and in Ireland the male:female suicide ratio is almost four to one (NOSP, 2009). Explanations for this variation range from essentialist, biological, arguments on the one hand to men's preference for using more lethal methods on the other. Durkheim suggested that women were 'naturally' immune to suicide due to their social conformity (see Kushner, 1995). While this explanation lacks credibility today, a gendered perspective remains implicit in many (including sociological) investigations of suicidal behaviour (see Baudelot & Establet, 2008). A gender-difference paradigm is commonly used in this area – an approach which divides male and female behaviour and emotions along binary, oppositional, lines. Equally problematic is the fact that men and women in these studies are constructed as a single cohesive group, although this notion has been shown to be inherently unstable (Connell, 2002, 2005; Haywood & Mac an Ghaill, 2003). Both of these concepts underpin a prominent theme linking the rise in young male suicides over recent decades to the erosion of men's economic and family roles (see Frosh, Phoenix, & Pattman, 2002). Significant variations exist between men based on socio-economic category, ethnicity, sexuality, and other factors and these differences are reflected in suicide rates. Some men, rather than all men, are vulnerable to suicide, and this challenges a straightforward link between 'men' and these social changes (Cleary & Brannick, 2007). The oppositional construction of males and females implied in these accounts is similarly contested (Butler, 2004; Weeks, 2007). Yet gendered profiles relating to suicide have widespread currency in the media and elsewhere (Coyle & MacWhannell, 2002). These themes link completed suicide with rational and masculine behaviour (see Canetto, 1992, 1997), and suicide causation for men to the economic and work spheres, despite evidence to the contrary (Cleary, 2005). Non-fatal suicidal behaviour is connected to weakness and feminine behaviour, and its causation among women to emotional and relationship issues.

Beliefs about women's inherent emotionality and men's unemotionality are embedded in Western ideas about the dualisms of body and mind, emotion and reason (Whitehead, 2002, p. 175). Yet these ideas have not been tested in a large-scale way until recently, and findings show that male and female emotionality is not dissimilar (Simon & Nath, 2004). However, the expression of emotions is highly gendered, with males less likely than females to express emotions – although this is influenced by socio-economic and other factors (Kemper, 1990; Seale & Charteris-Black, 2008). Gender differences in expressive behaviour may therefore reinforce and reproduce beliefs about gender and emotion (Simon & Nath, 2004, p. 1169) and may help to account for the paradox of higher reported psychological distress for women, compared to men, but higher rates of suicide for men (see Gunnell, Rasul, Stansfeld, Hart, & Davey Smith, 2002).

An inability to express emotions, especially distressing emotions, has been cited as a risk factor for suicide (Clare, 2000), and this is linked theoretically with the idea that particular constructions of masculinity endanger men's health (Courtenay, 2000). Masculinity is not a homogeneous, nor consistent, entity in any social grouping (Lohan, 2007). However, it is possible to identify patterns of behaviour that are considered enactments of a dominant or hegemonic masculinity (Connell, 1995; 2002; 2005). Men who endorse these more conventional norms of masculinity have greater health risks than other men (Courtenay, 2000). These men tend to share certain attitudes to health and help-seeking and this may be a contributing factor (Peate, 2004; O'Brien, Hunt, & Hart, 2005; Oliffe, 2005). Hegemonic or conventional forms of masculinity construct men as stoic and invulnerable which constrains them in seeking help for both physical and psychological conditions (O'Brien et al., 2005; Emslie, Ridge, Ziebland, & Hunt, 2007; Noone & Stephens, 2008). Within this construction of masculinity, admitting to psychological distress presents particular difficulties as it implies weakness and is connected to the feminine domain (Bendelow, 1993; Robertson, 2006a). Failure to disclose emotional pain may intensify distress and put them at higher risk for suicidal behaviour (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Courtenay, 2000). These beliefs and practices are not shared by all men, not even all those within similar environments, but they are still prevalent (O'Brien et al., 2005). Kimmel and others speculate that these attitudes emerge from a socialisation that teaches boys the importance of projecting strength and concealing emotions and pain (Connell, 2002; Frosh et al., 2002; Kimmel, 1994). This can prevent the development of emotional knowledge that might explain why some men have difficulty in identifying psychological symptoms (Addis & Mahalik, 2003). At the same time male rates of substance misuse are significantly higher than female rates in most countries. As alcohol misuse is a recurring theme in studies of men attempting to deny and cope with psychological distress this may form part of the story of male suicidal behaviour (see Brownhill et al., 2005).

These findings provide the theoretical and empirical rationale for this study. Some, not all, men are vulnerable to suicide; risk is age and class related and those most at risk are young males from disadvantaged backgrounds (Gunnell et al., 2010; Lorant, Kunst, Huisman, Costa, & Mackenbach, 2005). From work examining men's help-seeking patterns, it appears that particular kinds of masculinities may be implicated in suicidal actions. The aim of this paper is to examine this qualitatively, drawing on the narratives of a sample of young men who made a suicide attempt. Following Douglas (1967), the focus is on the subjective meanings and patterns generated by these stories of suicide, and on the processes through which men conduct gendered lives in their socio-economic environment (Connell, 2002; Haywood & Mac an Ghaill, 2003).

Methods

This study, funded by the Irish Research Council for the Humanities and the Social Sciences, was carried out over a period of two and a half years between 2000 and 2003 and is based on interviews with a group of men who attempted suicide. The objective of the investigation was to understand the practice and to explore the background circumstances and motivations involved in the suicidal behaviour. A qualitative methodology, based on in-depth, unstructured, interviews, was used.

Sample and data collection

Inclusion criteria included gender (male), age (18–30 years) and intent, in that all those included in the study had made a suicide attempt with definite intent to die. This age and gender group was chosen to reflect the population group with the highest rate of suicide in Ireland and other Western countries. A consecutive sample of 52 men was selected from three hospitals in the Dublin area within the same general geographical area. Two of the hospitals are district hospitals (with major Accident and Emergency units as well as psychiatric centres) and the third a psychiatric unit, which admits patients from a nearby general hospital (also an A&E centre). The sample can be regarded as representative owing to the seriousness of the attempts, because these hospitals were likely to receive all such admissions from this area over the period of the study. Participants were referred, in general, by the liaison

psychiatrists working in the Accident and Emergency Departments of the hospitals. One man refused to be interviewed. The participants were interviewed, by the author, as soon as possible after a suicidal action (depending on the extent of their injuries) but usually within 24 h. An unstructured interview schedule was used in the session consisting of one introductory question 'Can you tell me how you came to be admitted here?' Thereafter, no further preset questions were asked but questions were asked in response to issues raised by the respondent. This approach was adopted in order to elicit free flowing responses from the men in relation to the suicidal action, and to avoid pre-categorisation of actions or motives. Interviews lasted approximately 1 h, but some were considerably longer and were (audio) tape recorded. All but two men agreed to this; in those two cases I took notes, which I wrote up following the interview. I also recorded notes and observations on the interviews after each session. The interviewing style was informal with an emphasis on listening. I viewed the interviews as co-constructions between interviewer and interviewee, out of which would emerge narratives of suicidal action. This does not imply, however, uncritical acceptance of their accounts of themselves. My position was that of an academic researcher from a university, and I emphasized both verbally and in the consent form that I had no connection with the study hospitals.

Data analysis

The interview tapes and field-notes were transcribed and the analysis carried out via computer and manual methods. The data were analysed using a modified version of grounded theory (Strauss & Corbin, 2008) and guided by Douglas's (1967) methodological approach. I read all transcripts and field-notes a number of times, to obtain a comprehensive picture of the data. From the beginning, some regularities were identifiable – not surprisingly constructed around explanations for the suicidal behaviour and the way in which the suicidal pathway developed. Sub-themes related to the latter included enduring emotional pain, inability to disclose pain and the reasons for this. These form the basis of this paper. I then used a computer program for qualitative data analysis (NUD*IST) to identify frequently occurring words and phrases linked to these themes. I also produced a summary note relating to each participant based on the transcript and field-notes. Following this I re-read the transcripts, field-notes and individuals' summaries continually to establish themes. I then examined relevant literature and moved back and forth between the literature and transcripts to develop the thematic analysis. Theoretically the analysis was driven by a social constructionist framework and more specifically by the work of masculinity writers such as Connell (1995; 2002). Participants' constructions of masculinity were central to the analysis of the data but while their narratives contained frequent references to what men do, think and feel, none specifically mentioned this word. In writing up I used verbatim quotations to stay as close as possible to the meanings the men attached to their actions.

Ethical considerations

Consent for the study was obtained from the Hospitals' ethics committees. Before referral, the individual was informed that the study was completely separate from his treatment regime and that participation was entirely voluntary. When I met the potential participant, I explained the nature of the study in greater detail and again emphasised the voluntary, confidential, and independent (of treatment) aspect of participation. Participants therefore had a number of opportunities to decline an interview, which represented an important safeguard for them at a vulnerable time. The data were de-identified before it was removed from the hospitals and the list of participants, to which only the author had access, was kept in a locked environment in the university. Pseudonyms are used in this paper.

Findings

Background details

The mean age of the participants when they were first interviewed was 23 years and the range was 18–30 years, in line with the study criteria. The majority (94 per cent) were single and they were all born in the Republic of Ireland. The most commonly used method in the suicide attempt was an overdose of drugs (58 per cent) and approximately 25 per cent used methods generally categorised as particularly lethal (hanging, shooting etc). The biographical details of the sample confirm an association between lower socio-economic status and risk of suicidal behaviour (Gunnell et al., 1995). Almost half (48 per cent) worked in unskilled jobs and they came primarily from unskilled (46 per cent) and skilled manual (42 per cent) backgrounds. Less than 40 per cent had a Leaving Certificate (the examination taken in Ireland at the completion of second level schooling), which means that their average level of educational attainment was considerably lower than the national average in Ireland (Clancy & Wall, 2000). Over one quarter (27 per cent) of the participants had been in trouble with the law and they tended to come from neighbourhoods categorised as socially disadvantaged. These areas consist predominantly of public housing and include a high level of indicators signifying disadvantage, such as lone parent households and a concentration of lower SES groups (Haase & Pratschke, 2005). Redley (2003) has suggested that living in disadvantaged areas creates a particular risk dynamic for suicidal behaviour which is related to lack of control over one's life. Lower levels of education and poverty imply fewer options and less likelihood of disengaging from this world (Baudelot & Establet, 2008). The lack of options was mentioned by some of the participants, including Sean, who left school without any qualifications.

> You need money to go to college but if someone went to (mentions name of university) then they'd have change in their life. Like if I had my Leaving Certificate I probably wouldn't be talking to you now. (Sean/23)

Jim, who was the only pupil in his class to complete the Leaving Certificate, linked low educational attainment to the experience of schooling in disadvantaged areas.

> I suppose school is the thing that leads on to so much. I suppose wealth means you don't have to worry about basically stupid little things. … It wasn't the best school in the world. They wouldn't let you do subjects that you wanted to do. They'd kind of fob you off, that kind of thing, you know. Just when things start going like that you know you're not going to be going anywhere. You have the ambition, they don't. (Jim/47)

This theme of lack of control over one's life will be considered later in the context of decisions about suicidal action. The environment they inhabited also had relevance for the way masculinity was constructed and performed and this is discussed below in relation to the nature and duration of their emotional pain and how they dealt with this.

A narrative of long-term pain and distress

Gendered beliefs about men's un-emotionality and women's emotionality are often presented as uncontested, despite evidence that males and females differ little in terms of the experience of

emotion, including emotional pain (O'Connor, Sheehy, & O'Connor, 2000; Simon & Nath, 2004). The resilience of these dualistic constructions may be partly explained by the fact that men's emotional lives are relatively un-researched (Ridge, Emslie, & White, 2011; Whitehead, 2002). In this study, the participants spoke of emotional experiences extending over their lifetime and of the intense emotional pain they had been enduring for some time. The emotional distress related to the suicidal action was almost always present for at least one year and sometimes for much longer.

The prevalent emotions at interview were sadness, anxiety and panic, but they had difficulty identifying the specific nature of these feelings as illustrated in Ian's narrative.

> I'm miserable and I don't know why. You don't know why you are that way, you don't know what's wrong with you. (Ian/25)

This unfamiliarity with psychological signs is also apparent in Paul's account. He had been experiencing depressive symptoms for some years but was unable to identify the condition until he was admitted to the hospital.

> I was just depressed. Looking back to it, I would never have called it depression but its been there for about four or five years. I couldn't tell you why it started or what happened. It's been with me for about that time, four years ago. You don't think about tomorrow never mind think about the next year. You never make plans for anything. Everything just runs into another day. I wasn't happy. There wasn't really a build up. As I said you don't see a future. (Paul/6)

There were examples of participants who framed psychological symptoms as physical illness – a feature that has emerged in other studies of men's health and emotions (Bendelow, 1993). Tom, who suffered a number of panic attacks, described how he responded to these.

> I thought I was having a brain haemorrhage or something, a heart attack. (Tom/26).

This inability to recognise and label non-specific feelings of distress as emotional problems has been identified in other studies (Addis & Mahalik, 2003; Emslie, Ridge, Ziebland, & Hunt, 2006; 2007). Addis and Mahalik (2003) speculate that this may partly explain gender discrepancies in mental health statistics. This lack of knowledge may also reflect the participants' socio-economic background as those in higher socio-economic categories appear to draw on more diverse emotional and psychological discourses (Seale & Charteris-Black, 2008). When participants drew on bio-medical frameworks they tended to refer to depression, which appeared to be the only psychological concept they were familiar with.

> The pain, and I don't know whether it was depression. I was very sad, you know. … it's a very brutal feeling. I can't describe it. I wouldn't say it's depression. I don't know what it is. (Shane/27)

This discussion implies that problems and psychological symptoms had generally been present for some time but that participants had difficulty in identifying the nature of these symptoms. Emotions were relatively unexplored and they had little experience in emotional expression, because they were fearful of the consequences of disclosing distress.

Concealing distress

The longstanding problems these men were experiencing were not apparent to their social network, because they actively concealed their distress. As in studies of male help-seeking practices, a perceived stigma was attached to the expression of emotional pain (O'Brien et al., 2005). Non-disclosure was a widespread and prolonged pattern of behaviour, and only one participant had spoken (to a family member) about the distress which led to the suicidal action. Brian, who described a wide circle of friends and a caring family, illustrates this practice.

> For two years when I did feel down, I didn't talk to anyone. I just kept it all inside. I just didn't tell anyone anything. I just didn't like talking about my feelings or anything. I just didn't want to involve anyone, I just didn't want anyone else to tell. Hoped that by just ignoring it and left it alone, it would go away but it didn't. (Brian/24)

Brian's decision to conceal his difficulties was related to fears about disclosing emotional vulnerability, and this was a common theme. Expressing emotional distress was viewed as weakness, as is evident in David's account. He had considered telling a family member about his distress right up to the time of the near-fatal attempt he made on his life but had decided against it.

> I thought of it but I didn't do it. You're telling someone you failed. I feel like I failed, that's why I did that [attempted suicide]. They [men] don't tell anyone about their problems. Men feel they have to be strong, that you have to be able to manage when you are a man. (David/28)

Disclosure of emotional pain was also linked to the feminine, which resonates with Noone and Stephens's (2008) findings.

> I think because we're afraid to. Not to seem weak. We're afraid of seeming weak or something. Because we have to have this image of being macho, we have to have this image of not being girls. (Adam/35)

Although some writers believe that male emotions have become less rigid (Seidler, 1994), these findings are closer to those of O'Brien et al. (2005) who found some participants extremely reluctant to disclose emotional distress. The persistence of these attitudes is underlined by Emslie et al. (2007), who showed that when men receive treatment for mental conditions they find it necessary, as they recover, to reconstruct their masculine identities within a hegemonic framework. The following narrative illustrates this unwillingness to address psychological issues. However, Adam acknowledges an element of performance in relation to this, that these norms are adhered to in public but their instability is recognised in private.

Adam:	Mental illness is very kind of hush-hush among young men. It's taboo. Any kind of mental illness seems to be taboo among young men, that's what I think. Just not discussed, not mentioned, not paid attention to.
AC:	Do you think some of them are in distress?
Adam:	Yeah, I think a lot of them are but they just don't admit it.
AC:	How would you notice another man is in distress, say someone your ownage?
Adam:	You wouldn't, that's the weird thing, you wouldn't notice at all.
AC:	So how would it emerge then?
Adam:	Maybe when one of them tries to kill themselves or something.
(Adam/35)	

Conventional constructions of masculinity influenced decisions not to disclose to family and girlfriends or partners. Difficulties were not discussed with fathers, since they might be unresponsive or rejecting. Communication with mothers and with girlfriends/partners was not attempted, in order to protect them ('I didn't want to upset or frighten her' (Leo/34)). There was also a desire to project strong masculinity, for there was a corresponding theme that women needed, and wanted, strong masculinities.

She doesn't need any of that on her shoulder, you know what I mean. She could easily go out and find someone else that hasn't got any problems like that and just have a normal life without any extra grief or any extra worry. (Richard/52)

The participants did not access help within their family and friends and neither did they seek professional assistance. According to Courtenay (2000), men are still significantly less likely to ask for assistance for psychological conditions because dominant themes of men as invulnerable, as not needing help, are still common. It also appears that health professionals may collude with these ideas about men and their health practices (Seymour-Smith, Wetherell, & Phoenix, 2002). The participants had little faith in the efficacy of therapeutic interventions, especially talk-based therapies – a theme which appears in other studies (O'Connell & Clare, 2004; Russell, Gaffney, Collins, Bergin, & Bedford, 2004). Some participants had been offered counselling in the past, but had either refused or failed to engage with it. As Jim implied, the view was that counselling might offer temporary relief, but couldn't transform their lives in the way they wanted.

I don't really see where it gets you. You're still in the same place. (Jim/47).

As this discussion implies, there was conformity to conventional masculinity norms which constrained emotional expression. Adherence to these norms may well have been at an unconscious level, as Bourdieu (1994) has suggested, and influenced by socio-economic position (Seale & Charteris-Black, 2008). These masculinity rules were contested, and the majority of the men were aware that there was a performative quality to these practices. Yet, as in O'Brien et al. (2005) study, the participants felt significant pressure to conform, and this was enforced by other men in their families and in their wider environment.

The surveillance of masculine behaviour

Knowledge about how 'normal' masculinity should be performed was generally learnt in family settings and reinforced in peer and school environments, as Connell (2005) has described. Family members – especially fathers and male siblings – were important enforcers of dominant values, as illustrated in Ian's story. He described how he was often the target of teasing by his older brothers because he is 'too sensitive'. When he complained to his father about this he was told to 'stop whingeing, stop your moaning about it' and Ian accepted this criticism.

He was right and I should have because they all mess with each other. They have a laugh with each other and you want to be a part of that, have their little joke and that. … I get unsettled too easily and take it out on them, and because I'm not happy, 'you're not going to be happy, I'll ruin it for you'. Making my problem everyone else's problem. (Ian/25)

There were clearly-stated rules about communication with male friends, which had been learnt from childhood on (see Kiesling, 2005). Interaction between men involved particular performances, which did not include feeling or emotion. As in O'Brien et al. (2005) study, participants were fearful of other men becoming aware of their distress, as Tom suggests.

Lads can't turn around and talk to their friends. If you turned around and gave a sign of being weak and stuff like that, you'd be ridiculed. There's no way you could show your emotions like that. I think women are better at dealing with their problems. Women are more able to talk about it. Men, if they feel depressed or whatever, they see themselves as being weak and man is supposed to be the stronger one. (Tom/26)

Many were aware from past experiences that deviation from conventional behaviour was unsafe, and those who had been bullied in school (a relatively common occurrence) were particularly conscious of this. Bullying, which is linked to suicidal behaviour (Cleary, 2000), delineates acceptable and unacceptable male identities for boys and men (Connell, 1995, p. 79). It was apparent that these communication norms were shared by male friends, because participants frequently cited men as unreceptive to emotional communication. There were examples in the study of participants attempting to speak to male friends about their distress, but they had received definite cues that this communication was unwelcome. Particular neighbourhoods could sometimes increase the need to hide vulnerability, as Richard explained.

Other people would take it on you, you know what I mean, as being weak like. And then try and use it against you, you know that kind of a way, like. I've always grown up in a bit of a rough area, you know what I mean. My whole life has been surrounded by drugs, so you don't like to leave out, don't like to give any sign of weakness or tell your closest friend that you might be this or you might be that, you know what I mean. People can turn and use it against you, you know that way. That's why I wouldn't say anything to anyone. I think for men it's more important to show strength than women, you know, especially with say, towards another female or towards another male, you know. (Richard/52)

As Kimmel (1994) has suggested, deviation from conventional masculinity norms was linked to being feminine and to being gay, and gayness was associated with the feminine. Peter's narrative is both a confirmation of these attitudes as well as an indication of their instability.

You just get shunned if you're different. That's being a fag. When you're growing up there's a lot of pressure not to be gay. … If you're gay you get an awful time. …Gay and feminine is the same. …They just think that what you're wearing or the way you stand or the way you sit or your hands move when you talk that you're gay so you get punished for that in society especially when you are teenagers and I certainly did. (Peter/20)

In this kind of setting establishing an open gay identity was particularly challenging, and the inability to come out to family and friends was a key factor in at least two of the suicide attempts. Gary's account of how his life was constrained provides some insight into the higher rates of suicide among men with same-sex sexual orientations (Fergusson, Horwood, Ridder, & Beautrais, 2005; Russell & Joyner, 2001).

I thought it was all the fact that I was gay. I even find it hard now. I found it hard to deal with. I found it very, very, hard. I thought it a kind of secret. I've always known but I've always hidden it. Even as a young fella growing up. I never got any hassle but I could see my friends at the time. I'd see the way they'd be at other people and I'd be you know 'oh Jesus'. I could never tell. …Because I think they see you different. Probably mostly men. I'd be very conscious of it. (Gary/30)

In the context of this surveillance, continuous self-monitoring of behaviour and emotions was required to project an image of well-being. This was an additional challenge for the participants in the context of prolonged distress. The main way of dealing with this was to use alcohol and drugs.

Trying to cope: the use of alcohol and drugs

There is a significant association between suicidal behaviour and substance (especially alcohol) misuse, especially for men

(Hawton et al., 2003; Seguin et al., 2006). The association between alcohol and suicidal behaviour is linked to the availability of alcohol, and especially to the cultural acceptance of drinking (Brownhill et al., 2005). In Ireland, high levels of alcohol consumption, especially among young men, are evident (O'Connell, Chin, & Lawlor, 2003; Cleary, Nixon, & Fitzgerald, 2007; Health Research Board, 2010). Drinking may provide a camouflage for underlying problems as well as contributing to the under-reporting of male self-injury behaviour, as Canetto (1991) has speculated. The use of alcohol to self-medicate by the participants in the study provides some support for this.

Diagnostic categorisations applied in the hospital, as well as the participants' subjective accounts, showed high levels of alcohol misuse. Almost two thirds of the participants were misusing alcohol to some extent, one third of the men were misusing drugs at a serious level, and a further 17 per cent were using drugs intermittently. Alcohol and drugs were used extensively in an attempt to cope with emotional pain and stressful events, as well as to prepare for the suicidal action. Brownhill and colleagues (Brownhill et al., 2005) describe similar behaviour with male respondents in their study using alcohol to numb emotional pain. However, as both studies illustrate, substance use merely anaesthetised the feelings, and the participants faced additional problems when dependency developed. Richard's story illustrates this process, as well as many of the issues and practices discussed in previous sections of this paper.

> I suppose, for the last four or five years, I've been, I've been hiding, if you want. Hiding from everyone else. Denying, denying to myself that, like I was depressed, you know? And I was using all sorts of drugs to, just kind of, to go out to enjoy myself basically, you know that kind of a way. To forget about everything, to forget about it, you know that's what I was doing. To basically forget about it. And then, I had a steady job. You wouldn't have been able to tell me any different from any other fella up and down the street. You know that kind of a way. Then I met a girl, had a baby. It was only then, when [name] was born, I was really… But I didn't look for help or anything, but just thought right, I'll stop. It was only when I stopped that the depression started kicking in. You know that kind of a way, like. I wanted to stop taking the drugs. …Things were just deteriorating, you know. But I was afraid to tell her about me, about me being depressed, you know. I was afraid to tell her in case, she didn't want anything to do with me. I just hid it from her. Just never told her. Some days, sometimes you're grand, there's other days you're not. There were times where you just wouldn't get out of bed, you know that way. Just feeling isolated all the time, you know that way. Wanting to scream and shout but you can't say anything, you know that way. I never told anyone. I never wanted to admit to myself that I was, you know what I mean. I just wanted to forget about it, get on with it, you know that kind of a way, like. Probably none of this would have turned out to where I am now, you know. I should have stopped lying to myself basically, you know that kind of a way, like. Pretending that there was nothing going on, when really, you know, there is something going on, and there's something not right. (Richard/52)

Diminishing options: moving towards suicide

The strain of suppressing and concealing this level of distress resulted in a feeling of being trapped in an impossible situation. As there was no outlet for their emotional pain, a feeling of panic frequently ensued because distress was now affecting the body in terms of anxiety and sleeplessness. These symptoms, as Bendelow (1993) has suggested, may be particularly frightening for men who lack the knowledge to deal with emotional issues.

> I couldn't cope with it. I didn't want to live anymore. I just felt I had no choice. I'm not functioning normally. … I don't want to spend every day in hell. (Michael/22)

The participants were also restricted in bringing about change by a lack of financial resources and educational qualifications. Some had considered alternatives such as changing their lifestyle or moving elsewhere, but decided this was not feasible for these reasons. A lack of control over one's life was a feature of the narratives. This is illustrated by Ronan's comment.

> I'm just not happy with the way I want my life to be. Its just not going the way I want it. I'm just giving up. … I didn't want to go on. (Ronan/14)

A similar theme is evident in Redley's (2003) study of those who self-harmed in a low socio-economic community. His respondents' difficulties ('not living the life they desired') were viewed as outside their control, and this made them indifferent to the future (Redley, 2003, p. 269). Suicide as a response to helplessness, or as an attempt at control for those in powerless situations, has been noted in other studies (Weaver, 2009). Similarly, suicide as an escape from a specific dilemma is a well-established theme in the psychological literature (Shneidman, 1991). There were instances in this study of distinct problems from which participants wanted to escape, but usually the powerlessness was generalized, as in other qualitative investigations of suicidal behaviour (Fullagar, 2003; Redley, 2003).

Brownhill et al. (2005) described a similar 'accumulation of problems and psychological distress or emotional pain', leading to thoughts of suicide (2005, p. 925). In the same way participants in this study felt constrained by their emotional state and perceived narrowing of options – features identified in other studies of suicidal behaviour (Shneidman, 1991). In this context suicide offered the solution of ending their distress.

> You don't have many options and something like that is your best option, your best choice and you've got the choices but the only good one you have or the best one of them all … is to end it for yourself, end all your troubles, end all your worries and you'll never have to worry about it again. (Ian/25)

Thoughts of suicide emerged tentatively at first and were contemplated over time until the thought was more familiar and less fearful.

> I have often thought about it over a space of time. As a question to myself. Over a year I suppose just a question, a thought really. You might see something on the television, someone's committed suicide and you would think what way would I go about it, think that way, but I didn't think I'd ever. The others were just answering questions in your own head, what was I going to do or how was I going to do it. This time I was giving myself a way of doing it. (Aidan/2)

A suicidal setting had now been created, with thoughts of suicide giving way to more serious consideration, and sometimes rehearsal, of the action. At this point something relatively inconsequential, or a sudden impulse, or simply opportunity, might push the participants towards action. The timing of the suicidal action was therefore often relatively spontaneous and the precipitant, if any, not usually causative.

> I'd been thinking a long time of dying, but I didn't really know how you could commit suicide, that kind of thing, so, for a long time I didn't do it, you know. I didn't know how. And obviously I still don't 'cause I'm still alive. … I just, I had the opportunity

that day, kind of thing. I'd been thinking about it for a while, but then, ended up with loads of pills and stuff around, so I decided that I'd take them that night. This situation has been going on for a couple of years now, you know. Be easily going on for another few years. Well, maybe not now, but it would have, if I hadn't done anything. But that doesn't actually mean it was a big deep thought going into it or anything. (Jim/47)

Alcohol was frequently used in the action but was not, as Ian explains, central to the decision to attempt suicide. Its function was to give courage or anaesthetize feelings.

I wasn't in a bad way yesterday or anything like that. I just felt confident enough to do it. Probably drink didn't help but I wouldn't say it had much to do with it. It was more of a painkiller. Up to last night it was an option. It was a choice for me but I didn't want it to be because it's a horrible scary thing to do. I spent the last couple of weeks every once in a while thinking 'how will I write a suicide note?' I was always thinking, contemplating, it but last night I was thinking about how, you know, when something feels right 'do it' you know. (Ian/25)

Discussion

The findings in this study demonstrate high levels of emotional distress and the existence of long-term problems amongst a group of young men. The participants, interviewed soon after they made a suicide attempt, had difficulties both identifying symptoms and managing the distress and felt unable to tell their family and friends or seek professional help. They failed to disclose their distress because they identified this as un-masculine behaviour, and this was a view shared, and scrutinised, by other men in their local environment. Therapy was not sought because of the fear of exposure and because the men were unfamiliar with, or rejected, a psychological discourse – a theme that appears in other studies (O'Connell & Clare, 2004; Russell et al., 2004). In the absence of emotional disclosure and therapy, alcohol provided a culturally acceptable form of masking problems, which prolonged the men's denial and placed them at greater risk of suicidal behaviour. The extent of concealment in this study, as well as the methods used to deal with emotional pain, confirm other research findings and help to decipher the paradox of higher levels of reported distress for women, compared to men, but higher rates of suicide for men (see, for example, Gunnell et al., 2002).

This paper has proposed that study participants adhered to a hegemonic form of masculinity, and this had implications for their well-being and their suicidal decisions. This does not imply that masculinity is a consistent concept, but rather that masculinities of various kinds can attain relative stability in some social contexts and fluidity in others (Connell, 2002). And, even when these forms of masculinity are relatively stable, they will be contested, as in this study. While the participants conformed to a hegemonic type of masculinity which prevailed in their environment, there was a good deal of flexibility in relation to their compliance, as is evident in other studies of men's behaviour (Chu & Way, 2004; O'Brien et al., 2005; Robertson, 2006a, 2006b). The participants gave superficial allegiance to these norms because they recognised their local importance, because they were scrutinized by other men, and because they did not have the resources to leave the locality.

The majority of the men in this study were from low socio-economic backgrounds and in this, as well as their biographical details and educational attainment, they share many of the characteristics of those who are most likely to attempt and complete suicide (Gunnell et al., 1995; Kelleher, Keohane, Daly, Keeley, & Corcoran, 1999; Whitley, Gunnell, Dorling, & Davey Smith, 1999). Higher levels of wealth and education open up channels of knowledge about, and access to, health and health care as well as other forms of social and emotional capital (Baudelot & Establet, 2008; Seale & Charteris-Black, 2008). Middle-class males are not immune to the kind of distress described here but, in relation to suicide, they tend to inhabit less risky environments than the landscapes occupied by the men in this study (see Helliwell, 2007). Young men who lack socio-economic and emotional flexibility, and who are constrained by models of masculinity that inhibit the expression of distress, may be more likely to write this pain on the body. In this study it is possible to see what began as normal, if uncomfortable, emotions being channelled in negative, pathological ways owing to a lack of recognition, disclosure and intervention. Not all men are vulnerable to suicide and neither are all men from poor or disadvantaged environments. Men can, and do, share their problems with others and seek help (Emslie et al., 2006, 2007; O'Brien et al., 2005). The participants in this study represent a particular group of men with individual biographies. They shared values about masculinity and these values deterred them from speaking about their problems and moved them to disguise their difficulties and to self-medicate with alcohol. These findings point to the need for a more gender nuanced assessment of men presenting to health service facilities.

The array of emotions and distress evident in these narratives challenge simple dualistic categorisations of male and female emotions and feelings which Connell (2002) and others (Frosh et al., 2002) suggest are increasingly untenable. That men have active emotional lives and experience intense pain and despair is clear from the interviews on which this study is based. In the absence of hegemonic constraints the participants, who consistently spoke of never having divulged their feelings, produced long, emotion-laden, narratives. Hegemonic, conventional, masculinity constructs encourage men to deny their emotions and feel shame when they cannot live up to these ideals. There are alternative masculine discourses that facilitate emotion work in present-day society and these are becoming increasingly evident. The key finding here is that the expression of emotions is not equally fluid and flexible throughout society, and that there may be environments where the containment of emotions can have lethal effects for some men. In this way suicide may represent the externalized cost to society of the repression of normal emotions, the non-acknowledgement of a human need (Hochschild, 2010).

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