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The gender gap in suicide and premature death or: why are men so vulnerable?

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Abstract Suicide and premature death due to coronary heart disease, violence, accidents, drug or alcohol abuse are strikingly male phenomena, particularly in the young and middle-aged groups. Rates of offending behaviour, conduct disorders, suicide and depression are even rising, and give evidence to a high gender-related vulnerability of young men. In explaining this vulnerability, the gender perspective offers an analytical tool to integrate structural and cultural factors. It is shown that traditional masculinity is a key risk factor for male vulnerability promoting maladaptive coping strategies such as emotional unexpressiveness, reluctance to seek help, or alcohol abuse. This basic male disposition is shown to increase psychosocial stress due to different societal conditions: to changes in male gender-role, to postmodern individualism and to rapid social change in Eastern Europe and Russia. Relying on empirical data and theoretical explanations, a gender model of male vulnerability is proposed. It is concluded that the gender gap in suicide and premature death can most likely be explained by perceived reduction in social role opportunities leading to social exclusion.

Key words suicide · premature death · masculinity · gender · coping – social change

Epidemiological trends

Suicide and premature death are strikingly male phenomena. Despite generally low morbidity rates (Gijsbers van Wijk et al. 1992) the mortality rate of men is significantly elevated. The female to male ratio of committed suicide (Table 1) in Western societes is at least 1:2, and the highest ratio is found with 1:6 in the United States (Murphy 1998).

Taken together with death due to coronary heart disease, violence, accidents and drug or alcohol abuse, males, especially in the young and middle-aged groups, have a significantly higher risk of dying prematurely than their female counterparts. This is specifically documented by the so-called 'Central and Eastern health paradox' in Eastern European countries and Russia, where the gap in life expectancy between men and women has increased dramatically since the late 1980s. This increase cannot be completely explained by traditional risk factors. As this development concurs with the transition to a modern capitalist society, it is a natural experiment of how rapid social change leads to health deterioration, particularly in men, through interaction between social, mental and behavioural factors.

One alarming indicator for the high vulnerability of young men in general are the increasing rates of offending behaviour (Archer 1994), conduct disorders (Smith 1995), depression (Klerman, Weissman 1989; Fombonne 1994; Culbertson 1997) and suicide since the 1980s in most industrial nations (Hawton 1998, Crawford, Prince 1999; McClure 2000). After accidents, suicide is now the second most common cause of death in 15- to 24-year-old males in the United Kingdom, and is even the leading cause of death in several other European countries in this age group (Hawton 1998).

The growing divergence between male and female suicide rates since 1970, however, is not only due to a rising male rate, but also to a falling female rate. Time series analyses of US trends indicate that before 1970 the ratio converged since 1919 mainly because of a disproportionate increase in the female suicide rate, which has been explained by the great changes of female roles in the 1950s and 1960s, e.g. increase of divorce, changing attitudes towards fertility, education and participation in the labour market. These changes increased female stress and anomie as long as they had not become normative. After 1970 these changes reduced rates of female

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Table 1 International youth suicide rates (per 100 000) ranked by males, 1994*

Country	Male	Female
Russian Federation	48.8	9.0
Lithuania	45.6	12.0
Finland	45.5	7.8
Latvia	40.0	3.6
New Zealand (1993)	39.4	5.9
Estonia	37.5	9.6
Kazakstan	36.1	11.2
Switzerland	30.3	5.2
Slovenia	28.6	5.6
Austria	25.4	6.6
Mauritius	25.1	9.4
Canada (1993)	23.8	4.7
Australia (1993)	23.7	3.7
Norway (1993)	21.9	6.0
USA (1992)	21.9	3.7
Nothern Ireland	21.5	0.8
Scotland	21.5	5.6
Hungary	20.2	5.2
Belarus (1985)	19.8	3.4
Kyrgystan	18.8	3.0
Croatia	18.3	7.8
France (1993)	18.2	5.2
Poland	17.9	2.7
Republic of Moldova	17.8	5.7
China (selected rural areas)	16.7	33.0
Ukraine (1985)	16.7	3.3
Germany	13.9	3.7
Bulgaria	13.3	5.0
Turkmenistan	12.4	6.3
Japan	12.0	5.1
Sweden (1993)	12.0	6.6
Singapore	11.7	10.2
United Kingdom	11.5	2.2
Israel (1993)	11.3	1.5
Republic of Korea	11.0	5.9
Uzbekistan (1993)	10.4	5.6
England and Wales	10.0	1.9
Hong Kong	9.5	8.7
The Netherlands	9.1	4.1
Chile (1992)	7.6	2.4
Albania (1993)	7.4	3.5
Italy (1992)	6.8	1.8
Spain (1992)	6.8	1.3
Mexico (1993)	5.9	1.3
Georgia (1990)	5.6	1.0
Portugal	4.8	1.9
Greece	4.1	0.4
China (selected urban areas)	3.6	6.4
Tajikistan (1990)	2.8	4.9
Armenia (1987)	2.0	0.7
Azerbaijan	0.4	0.5

* unless otherwise stated
Source: World Health Organization (1996)

suicide and led to a divergence in the gender-suicide gap (Stack 1987; Austin, Bologna, Dodge 1992). As major depression is known to underlie more than half of suicides, and depression is about twice as common in women than men, the less lethal modern antidepressants (suicidal women prefer dying from intoxications compared to men who have a tendency to more aggressive methods) and the better detection of depression in women as a consequence of their help-seeking behaviour may also have contributed to the decrease in women's suicide rates.

One of the key challenges for suicide research is to explain the expanding gender difference (and, in relation to this, one of the remaining key challenges in gender-related depression research is to explain the gender paradox of a high depression and low suicide rate in females, and a low depression and high suicide rate in males). To date, there are several explanations including economic, cultural and psychosocial approaches, but more empirical evidence is needed for their validation. This is especially true for the gender perspective, which has been shown to be a powerful analytical tool in women's health research, but which is not yet systematically used with regard to men's health. Even though studies concerning somatic, especially cardiovascular diseases as well as studies on the impact of job stress traditionally focus on male samples, and norms of physical and mental health have been directed at male data, gender-related research on men's health and its determinants is rare.

The rising gender gap in suicide suggests that causal factors may have changed in different directions for men and women. Social factors, especially linked to gender-roles and changes in gender-roles, are considered to be the most likely explanation (Hawton 2000). More generally, Rutter and Smith (1995) regard cultural changes in Western societies as the main factors contributing to the trends in psychosocial disorders and suicide, being even more relevant than classical risk factors like social disadvantage, inequality and unemployment.

Defining gender

Gender refers to the socially constructed roles of men and women implicating different social norms and cultural expectations for both sexes. These norms and expectations define what is typical and desirable for males and females, and they are reproduced by early socialisation as well as by social institutions. They function as a script for the individual and have a central significance for self-definition, self-evaluation and self-regulation. As gender-roles have changed, concepts of being male and female (gender-role orientation, psychological androgyny) have gained high importance for explaining gender-related differences in behaviour and attitudes, because they represent a disposition influencing the selection, subjective meaning and satisfaction with social roles. Like the traditional female role before, the tradi-

tional male gender-role has now also entered into a process of dissolution, but inspite of this traditional notions of gender-roles remain influential (Wood et al. 1997). Interestingly, it has been found that self-reported gender differences are more pronounced in Western, individualistic countries (Williams, Best 1990).

Gender cannot be defined by two static categories, but rather by a set of relationships which are produced and reproduced by social interaction; thus, gender is something that one does (West, Zimmermann 1987). At the same time gender is a basic principle of societal organisation structuring social roles and the access to personal, social and material resources differently for men and women. For this reason gender is a significant determinant of health and illness, manifesting in gender-specific exposure to life stress, gender-specific stress vulnerability as well as gender-specific stress response and pathways to diseases.

Despite the controversy whether gender roles are purely cultural creations or whether they reflect preexisting and biological differences between the sexes in abilities and predisposition, the gender perspective offers an interesting analytical framework for integrating structural, cultural, individual as well as biological factors.

Traditional masculinity as a key risk factor for male vulnerability

Cultural code of male expressiveness

The traditional male gender-role, as defined and reinforced within the public realm, is characterised by attributes such as striving for power and dominance, aggressiveness, courage, independency, efficiency, rationality, competitiveness, success, activity, control and invulnerability. The male gender-role in Western cultures implies not perceiving or admitting anxiety, problems and burdens which might develop under the conditions of danger, difficulties and threats. Traditionally, anger, aggressiveness and hostility are socially accepted as the male code of expressiveness. Traditional masculinity is sharply outlined against attributes being socially defined as feminine. While the traditional female role is more diffuse and lacking in standards for success and failure, the male role provides clear standards by which success and failure can be measured.

Being fixed on achievement and success may guarantee social gratification and appreciation, with positive effects on identity and health; however, at the same time it may guarantee continuous pressure to meet expectations, fear of failure and suppression of distress. Adolescent males often respond to this with an 'excessive' masculinity (risk-taking, aggression, violence) to validate their male social status. As boys are taught to be stoical and to ignore symptoms ("boys don't cry"), the threshold for expressing pain and emotional sensitivity – especially related to emotions like weakness, uncertainty, helplessness and sadness – is heightened and results in emotional restriction. This masculine inexpressiveness is now empirically well documented (Grossman, Wood 1993; Traue 1998); as there are no gender-related differences in expressiveness in new-born children, emotional control increases with age (McConatha et al. 1997) and is associated with numerous adverse psychosomatic effects.

Whereas female identity is defined in a context of social relationship and communication, male identity is constituted by competitiveness and emotional isolation; males usually report only one confiding relationship with the opposite sex. In their social relationships they interact around external matters (sports, business, politics, hobbies), and feelings are not considered to be a fitting subject for discussion. Because men, in particular young men, are more competitive than females in a variety of domains (Cashdan 1998), revealing feelings of depression or helplessness would give advantage to others.

The masculine stereotype does not allow help-seeking, even if help is needed and could be available. Already perceiving a need for help would offend traditional role expectations, and admitting this need would be a double offence. For the same reasons, help-seeking implies loss of status, loss of control and autonomy, incompetence, dependence and damage of identity.

Reluctance to seek help

"Women seek help – men die". This conclusion was drawn from a study of suicide prevention in Switzerland (Angst, Ernst 1990). 75 % of those who sought professional help in an institution for suicide prevention were female, and 75 % of those who committed suicide in the same year were male. A general male to female ratio of 1:2 in physician utilisation is well documented. There is a marked discrepancy between help-seeking in men and need for help, not only with regard to emotional problems (Rickwood, Braithwaite, 1994) but also to the high rate of untreated depressive disorders among men (Wittchen et al. 1999, for review see Möller-Leimkühler 2002). However, before consulting a doctor, a sensation has to be perceived as a physical or psychological symptom. This is probably the central point, where biological, individual and social factors are catalysed contributing to a non-perception, underevaluation and denial of symptoms, thus producing barriers to help-seeking. Especially depressive symptoms are inconsistent with the masculine stereotype; they are held to be typical female symptoms and men are not supposed to suffer from them. It is the linkage between depression and femininity that may provide masculine men with the strongest motivation to hide their depression from others (Warren 1983). To hide their depression men rely on norm-congruent behaviour like aggressiveness, anger attacks, acting out, low impulse control and alcohol abuse, a gender-related response

pattern that has been hypothesised as the 'male depressive syndrome' by Rutz et al. (1995).

Alcohol and drug abuse

Alcohol consumption is a gender-role-appropriate behaviour for men, a symbolic practice for demonstrating masculinity, constituting masculine communities, 'self-caring', and distracting or alleviating depression. Data indicate a strong link between alcohol dependence and depression in men, while depression can also be a consequence of alcohol abuse. A recent study reported a depression rate in patients with alcohol abuse that was 4 to 5 times higher than that in the general population (Zierau et al. in press), and in 55 % to 70 % of substance abusers who committed suicide, depression has been found as a comorbid condition (Murphy 1998). Substance abuse was also found to be more prevalent in those male adolescents with a propensity for impulsivity, often associated with antisocial disorders and suicide (Chan 2001). As alcohol abuse acts as an agent of emotional disinhibition, it fosters impulsive behaviour and facilitates suicide. It can lead to a reduction of self-esteem due to failures in social roles and relationships and can result in isolation and loss of support, which increases the risk of depression and suicide.

The thesis "the greater the alcohol consumption, the greater the suicide rate" is also supported by aggregate over-time research for some nations (Canada, Sweden, U. S., France, Czechoslovakia, Hungary; Stack 2000).

Suicide and suicidal behaviour

Males who opt to behave according to traditional masculinity are not able to tolerate loss of mastery and control. Thus, suicide as a stress response is a last documentation of self-control to ultimatively change the situation. As a number of studies in the U. S. have shown, surviving a suicidal act is culturally perceived as an inappropriate behaviour for males (Canetto 1997). For example, college students have shown to be most unsympathetic towards suicidal males (White, Stillion 1988), which is an evaluation leading suicidal males to choose more lethal methods like firearms or hanging. Death by suicide in males was rated as less wrong, less foolish and less weak than death by suicide in females (Deluty 1988–1989); men who killed themselves were seen as more well-adjusted than women, particularly when they committed suicide because of an athletic failure, and not because of a relationship failure (Lewis, Shepeard 1992).

These gender-specific cultural beliefs and attitudes towards self-destructive behaviour may contribute to the explanation of young men's low rates of parasuicidal behaviour and their high rates of suicide mortality. However, as recent data from the UK indicate, the female to male ratio of parasuicidal behaviour has fallen from 2:1 to 1:1, apparently due to a rise in parasuicidal behaviour in young men (Hawton et al. cit. McQueen, Henwood 2002).

Changes in male gender-role may increase male vulnerability

In postindustrial Western societies there is a change of paradigms related to the perception and role of men. Since the women's movement and their participation in the labour market, as well as the collapse of the legitimacy of patriarchal power, the traditional male role has become partially dysfunctional and confusing, particularly with respect to occupational factors: working women have become rivals, they may be seen as threats to job security, which may be associated with perceived loss of control and self-esteem among males. Although the traditional gender-related division of labour has shifted and unemployment has become a rather probable period in people's life, causing males to spend more time in family or non-working roles, the working role has remained an essential constituent of masculinity. Together with a more pronounced pressure to earn money, unemployment, uncertainty about future employment, temporary and insecure employment may apparently have a much stronger impact on men's health than on women's, whose unemployment is culturally more accepted and who can better compensate because of traditional family roles. Increased occupational instability has been proposed as one factor behind the increase in suicide by young males, but as Hawton states, evidence is equivocal (2000).

Significant changes in social roles and reality for women have led to a deconstruction of traditional masculinity which has yet not been substituted by new role models for men. Although this offers the chance to gain more options for expressing emotions and behaving more flexibly (psychological androgyny), psychosocial stress and gender-role conflicts may arise from changing attitudes and conflicting expectations. Not long ago, everybody knew what a 'real man' or a 'real boy' is. A boy, for example, behaving in school in accordance with the traditional male role, is now discriminated by his teachers as aggressive and socially deficient. Boys no longer know what is male, and identity models are lacking. Current research on gender stereotypes and their cultural evaluation suggests that although gender-roles have changed, the content of gender stereotypes had remained stable over the years; however, they are differently evaluated by men and women: male-associated attributes, which were positively valued two decades ago, are now consistently less valued compared to female-associated attributes, which in turn are judged to be more socially desirable (Nesbitt, Penn 2000; Hosoda, Stone 2000). Williams and Best's (1982) large-scale crosscultural investigation examined the patterns of gender stereotypes in 30 countries, and a global analysis of the data revealed a clear tendency across cultures to stereotype men more negatively.

For male adolescents who are beginning to define themselves as adult men, it may be especially difficult to exist within or find alternatives to the traditional, fragmented category of masculinity that is likely to produce emotional distress, to which they may respond with stereotypical behaviour to feel more in control. This stress process for adolescent males is reinforced by additional developmental tasks and experiences in adolescence: school transitions, loosening family ties, first romantic relationship, decision-making about career, first job, marriage and becoming a parent, moving etc. Generally, in comparison to former periods, adolescence has now become a more difficult stage in life as a variety of stressors may lead to a cumulation of burden.

Postmodern individualism may increase male vulnerability

The role of cultural factors in suicide fits within a broader sociological tradition deriving from Durkheim's (1970) relation of suicide to social integration. He posits that in times of rapid societal change, suicide levels will increase due to either new-found prosperity or poverty, both of which can produce anomie or feelings of normlessness, helplessness and meaninglessness. During rapid transitions the stress-buffering effects of social institutions such as religion, family and community, which function as guides through the complexities of everyday life, are weakened as individuals are forced to adapt to new circumstances by loosening family and community ties. Levels of social integration undoubtfully play an important role in facilitating or preventing suicide, but as this explanation is related primarily to social structure, it does not include broader cultural qualities such as individualism (Eckersley, Dear 2002). Furthermore, it has to be considered that, although Durkheim conducted his work during the great societal transition from feudal to industrial society, these societies still possessed substantial levels of social cohesion, well-defined social structures, a collective consciousness and institutions that served to ease the burden of societal transition (Willis et al. 2002). Western societies of today are moving from being collectivistic (modern) to individualistic (postmodern) in nature, undergoing a comprehensive socio-cultural transition.

Individualism places the individual at the centre of a system of values, behavioural choices and convictions, and emphasises personal autonomy, independence and self-actualisation. Starting with industrialisation, individualisation was primarily related to the labour force, manifesting in education and professional competence, with the consequence of social mobility and a weakening of social ties; since 1970 there has been a further progression of the collective segregation due to grazing changes in education, mobility and competitiveness. Because of the deconstruction of traditional norms and central goal-setting institutions, individuals are set free from structural constraints to have a maximum of personal freedom in order to make options and choices in all areas of life, including the construction of identity. Another facet of individualism consists of increased expectations concerning romantic relationships, work, leisure, children and quality of life. The other side of the coin are multiple problems: responding to the discrepancy between expectations and reality, making the right decisions, when everything is uncertain and guidelines are lacking, assessing the consequences of a choice under the conditions of constant and unpredictable change, managing to control, prevent or minimise risk, preventing failure. As the individual is obliged to be free, there exists a variety of forms of social malintegration such as norm conflict, conflict between values and norms, conflict between values, conflict because of lacking norms, self-discrepancy between the perceived self and the ideal, conflict between role expectations and actual circumstances, and so on. An adaquate coping strategy, as Sennett (1998) has shown, is flexibility to respond quickly to unpredictable changes, however, adverse consequences of flexible self-management may be "drift": disorientation, dissolution of confidence and responsibility, a self being reduced to exchangeable fragments. In accordance with the observations of Sennett, other social theorists like Beck (1986) and Baumann (1999) define fragmentation as the main feature of postmodern societies. Fragmentation can be harmful to well-being through its influence on values, goals, expectations, hope, purpose, meaning, belonging, predictability and coherence (Eckersley, Dear 2002). Due to the systematic undermining of meaning, the subjective construction of meaning, the perception of reality as unstable and incoherent, and the self becoming weak and fragile, sociologists have called postmodernism the era of identity problems.

Following the argumentation of Eckersley and Dear, the costs of individualism in the "new" industrialised nations such as Australia, New Zealand, Finland, Norway, the United States and Canada seem to be the highest due to an excessive individualism that is probably less tempered by tradition and social obligation. These societies may be promoting a cultural norm of personal autonomy and attainment that is illusive and may result in a gap between cultural ideal, psychological need and social reality. According to Eckersley and Dear there are four dimensions of this gap:

- There may be an excess of choice and uncertainty that makes the developmental tasks of adolescents more difficult and leads to an overload.
- Because of its self-focus, individualism can undermine the fundamental human need to belong and to form lasting significant personal relationships – thus strengthening the masculine norm of social independency.
- Structural changes of recent decades (increasing inequality, poverty, unemployment) tend to increase the discrepancy between perceived and real choice and opportunity.
- Despite the loosening of norms and constraints asso-

ciated with individualism, life becomes increasingly regulated by new laws and rules due to the growing social, economic and technological complexity.

To cope with the above mentioned challenges of postmodern culture, the ability to tolerate feelings of ambivalence and uncertainty is of central importance, including a positive evaluation of ambiguity, conflict and negotiation. Also of central importance are social relationships which have to be individually established and maintained.

It is plausible that some facets of postmodern individualism may adversely affect males more than females.

- As females are more likely to perceive themselves as interdependent, they remain better socially connected, suggesting that individualism is less isolating for females. It is a well-known fact that marriage is a protective factor for males, and that they are more vulnerable than females to suicide after the break-up of their marriage, with some evidence that younger men are particularly at risk (Cantor, Neulinger 2000).
- Negative emotions such as pessimism, anxiety, uncertainty, weakness or sadness may have higher psychological costs for males in a postmodern society of "winners", where all other males seem to be happy, healthy, optimistic, competitive, successful and self-actualised.
- In general, traditional male gender-role expectations are apparently reinforced by individualism, thus promoting a more androgynous gender-role orientation for females, which has been shown to have positive effects on their well-being. However, due to the dissolution of traditional masculinity, and the mixture of traditional and non-traditional social expectations, a conflictual tension can emerge for males that may be experienced as double binding.

To conclude, especially male adolescents may increasingly experience feelings of ambivalence, helplessness and hopelessness. In case of family conflict or broken home situations and/or lower socioeconomic status they have even fewer resources to cope with their conflicts, which will further increase their perception of lacking control over their social environment and increase their vulnerabilty to risks of all kinds.

Rapid social change may increase male vulnerability: the case of the post-communist countries

The implications of traditional masculinity for health under different societal conditions are particularly highlighted by morbidity and mortality rates in Central and Eastern Europe as well as in Russia. Since the 1960s the health of both men and women has been deteriorating in many of these countries, while the impact has been much greater for young and middle-aged men through premature deaths from cardiovascular diseases and suicide. As Watson (1995) pointed out, state socialism, because it excludes individuals systematically from the public life of society, had fostered a neo-traditional (counter)culture, in which the family and the household were of central importance to survive and (early) marriage was the golden key to cope with life, thus buffering stressful experience resulting from unmet expectations in public and work life. While this cultural structure strengthened the traditional family roles of women (independent from also being employed), it limited the opportunities for realising traditional masculinity by social exclusion: research has shown that men more frequently missed a meaningful role at work to show initiative and demonstrate their competence, while women felt they have a meaningful role in the family for which they do not have enough time given that they were also employed. "'Keeping going' in Eastern Europe thus meant (and often still means) keeping the family going, where this depends crucially on the paid and unpaid work of women" (Watson 1995, p 932). The importance of the private sphere and the assumption of a particular male vulnerability under state socialism has been consistently supported by data which indicate that the rise of premature male mortality has been concentrated in the non-married population: men who were excluded from the family and marital role were likely to suffer from an increased amount of stressful experience. 'Not being married' and 'reporting marital problems' were two independent predictors of an elevated risk of premature male mortality (Watson 1995).

Considering the decline in men's health and the rapidly growing male mortality rates in Eastern Europe and Russia after 1990, following the massive rise in unemployment, the collapse of state socialism was obviously even more dramatic for males. In Russia, mortality rates of men are about 500 and of women about 80 per 100 000 per year. Between 1990 and 1994, life expectancy for Russian men decreased from 63.8 to 57.7 years; for women, life expectancy decreased from 74.4 to 71.2 years, resulting in the widest gender gap anywhere in the industrialised world (Weidner 2000). Most affected were middle-aged males, in particular urban male populations with a lower level of education (Shkolnikov et al. 1998). As several researchers have pointed out, the rapid decline in men's health, especially their vulnerability to coronary heart disease, cannot be sufficiently explained by traditional coronary risk factors and lifestyle variables (bad diet, smoking, alcohol abuse) nor by biological or genetic factors when compared to Western Europe (Weidner 2000, Ginter 1995). Additionally, empirical evidence suggests that it is not the economic change in post-communist countries itself which directly affects health, but it is mediated by subjective evalution via psychosocial factors, especially depressive symptoms and perceived control (Kristenson et al. 1998, Kopp et al. 2000, Bobak et al. 2000). As males are obviously more affected by socioeconomic stressors (unemployment, income deprivation, loss of status, incongruities with regard to education and occupation), they must have other psychosocial risk factors than females.

These psychosocial factors, some of which have been identified in several studies as risk factors for coronary heart disease (Weidner 2000), are all associated with the cultural standard of traditional masculinity as described above, making adaptation to the new circumstances more difficult.

- Males are less socially integrated, they report fewer sources of social support, and their spouse is often the only source of support. Thus, their health becomes more affected by partner loss and may be more affected by social disruption in post-communist countries. Due to their family roles, larger social networks and interpersonal coping strategies women may be able to cope better with change than men.
- In stressful situations men have less adaptive stress response than women. They are more likely to use avoidant coping strategies such as denial and distraction to defend their position as well as to increase alcohol consumption, which has been revealed to be one of the main causes of premature deaths in Russia (Nemtsov 1999). As Voytsekhovich and Redko (1994, see Mäkinen 2000, p 1407) state, "alcohol has become a catalyser in the sociopsychological disadaption of personality as a result of the economic problems, the worsening quality of life, and the spread of micro-social conflicts".
- Rapid social change, when goals and norms are being redefined, is likely to evoke high alienation with the individual feeling powerless, meaningless, normless, isolated and self-estranged. Being confronted with unavoidable, emotionally negative life situations which cannot be controlled by the individual may result in feelings of helplessness, hopelessness and vital exhaustion, which have been linked to depression and cardiovascular morbidity and mortality. Because social status via the working role is essential to male identity, as is having control over their environment and work (Siegrist 2000), they are more vulnerable to achievement and occupational stressors and powerlessness. Given that they experience relative socioeconomic deprivation, and that they are not able to improve their situation by "fighting or flighting", they will experience loss of control, helplessness and depressive symptoms, which is detrimental to their masculine identity. According to the norms of traditional masculinity, they respond to these emotions with denial and other negative masculine coping strategies, which might help explain the finding that for males, the health consequences of depressive symptoms, particularly with respect to cardiovascular mortality, are more severe than for females (Musselman et al. 1998). Socioeconomic stressors may have either a direct effect on male cardiovascular morbidity by influencing their physiological stress response or an indirect effect by promoting adverse behavioural and emotional responses associated with increased risk of cardiovascular diseases.

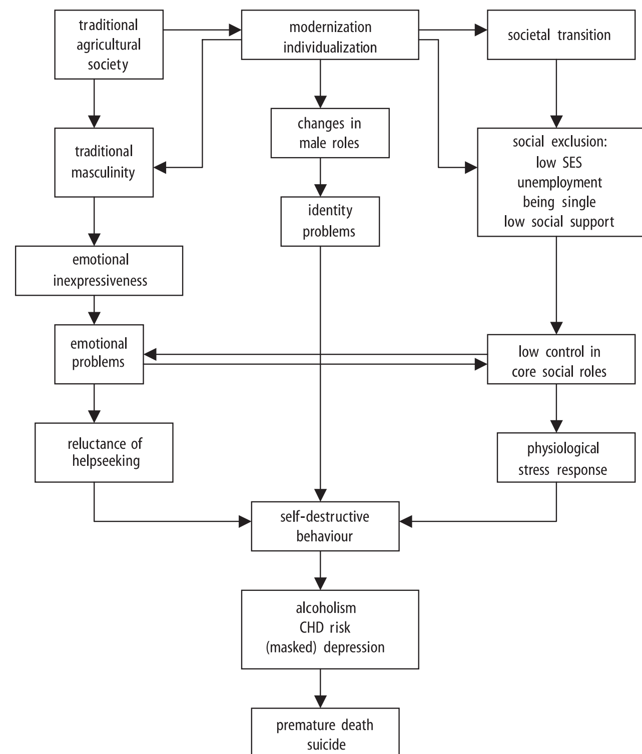

Fig. 1 Gender model of male vulnerability

Conclusions

The relative vulnerability of males (Fig. 1), especially young and middle-aged males, whether they live in Western or Eastern Europe or in Russia, can most likely be explained by the perceived reduction in social role opportunities leading to social exclusion.

According to individualism, reduced life chances, especially loss of work and long-term unemployment (which is still more substantial for male than for female identity), are rather attributed to personal failure than perceived as a societal problem, resulting in identity problems, loss of control, helplessness and depression. Males respond to this with maladaptive coping strategies, triggered by norms of traditional masculinity or confusion resulting from gender-role conflict: emotional inexpressiveness, lack of help-seeking, aggressiveness, risk-taking behaviour, violence, alcohol and drug abuse and suicide. Male sex is a fate, but masculinity is not: it rather represents a social construct that can be changed in order to improve male stress response and reduce high rates of suicide and premature death.

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