**How men step back – and recover – from suicide attempts: A relational and gendered account**

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# How men step back – and recover – from suicide attempts: A relational and gendered account

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**ABSTRACT**

Men account for three-quarters of suicide deaths in the UK, yet we know little about how at-risk men construct their experiences of moving toward - and then subsequently stepping back from - suicide, nor the part played by relational factors therein. An inductive thematic analysis was used to examine narrative interviews with eleven UK men who self-reported serious thoughts, plans, and up-to and including suicide attempts in progress, but who consciously decided against carrying out an attempt. Their accounts suggest a highly social process of movements towards and away from suicide (e.g. frustrated help-seeking). Stepping back from suicide represents not a discrete issue, but a linked process in suicidality and wider recovery. Here, the use of military metaphors in particular (e.g. waging war, fighting back) highlight the gendered nature of the issue. Additionally, our article illuminates a range of social relations and forces that circulate in and around suicidality, which itself is embedded in varying forms of relationality, normativity and gendered practices.

## INTRODUCTION

The relatively high prevalence of suicide in men in Western societies suggests a gender dimension which, although well studied, is complex and difficult to interpret. Men account for three-quarters of suicide deaths in the UK (ONS, 2017), and this pattern is relatively consistent across Western countries (Hunt, Sweeting, Keoghan, & Platt, 2006). Despite all the work done toward increasing the understanding – and prevention – of male suicide, effective interventions are still lacking (Van Orden et al., 2010). Evidence in the literature suggests that male suicide risk is especially linked to alcohol or substance use, unemployment, depression (Möller-Leimkühler, 2003), relationship breakdown, poverty (Coleman, 2015), divorce and separation (Hawton, 2000), as well as lack of social connectedness (Legleye, Beck, Peretti-Watel, Chau, & Firdion, 2010). One of the problems is that risk factors for both suicidal thoughts and completed suicide are similar (Gunnell, Harbord, Singleton, Jenkins, & Lewis, 2004). This makes an understanding of why people might step back from suicidality (e.g. plans, intent, thoughts) especially important.

Prevention programmes for men variously attempt to increase awareness, normalise help-seeking, provide psychological support of mental health problems, and encourage greater openness about mental health problems (Struszczyk, Galdas, & Tiffin, 2019). Although an increase in the male suicide rate in 2019 was the largest since 2000, the trend in male suicides in England and Wales is generally downward since the early 1980s (ONS, 2019). Thus, there is always hope that it is possible for men to turn away from suicide, as well as for professionals to help prevent male suicide. In particular, there is capacity to learn more about how men with direct experiences of suicidality (including those who consciously abandon a suicide attempt in progress), understand their avoidance of death. Thus, our study aimed to address these gaps in the literature by asking: how do men

construct their journey toward, as well as stepping back from suicidality, and what part do (inter) relational factors play in the latter? First, we begin by examining the theoretical and empirical literature pertaining to suicide and gender.

*Towards the relationality of suicidality*

As an aspect of human behaviour, suicide has disturbed and fascinated scholars for millenia (Barbagli & Byatt, 2015). Those interested in suicidality have developed a diverse range of theoretical ideas, from the biological through to the social (Van Orden et al., 2010). Durkheim famously proposed suicide to be a social phenomenon, connected to an individual's level and type of integration to society, as well as society's equilibrium (Durkeim, 1951). Durkheim's proposing of *anomie* as a condition of society itself that leads to suicide via social breakdown, disillusionment and confused moral norms has particular resonance with contemporary western society. Durheim's theories, while hugely influential, reflected traditional patriarchal norms, and masculinity remained unproblematised (Jaworski, 2014), whereas in more recent explanations of suicide, gender has become a greater focus of explanatory frameworks (Scourfield, 2005; Niehaus, 2012). For example, Schrijvers and colleagues (2012) note important gender differences regarding suicidal behaviour, with an overrepresentation of females in non-fatal suicidal behavior and a preponderance of males in completed suicides. The authors identify a suicide 'process', from suicidal ideation through to suicidal behavior, including plans, self-harm and fatal suicides, which in males is considered a shorter process than in females (Schrijvers, Bollen, & Sabbe, 2012). This conceptualisation suggests that a more in-depth understanding of the suicide process itself (including the turning back from the act of suicide itself), may be useful for interventions aimed at prevention.

Also prominent in the suicide literature are individualistic theories seeking to explain suicidality. Here, there is no single suicidal personality identified, but rather a constellation of suicide-producing qualities that varies from person to person. However, Shneidman's (1998) theory of 'psycache', suggests mental pain is a requisite for suicidal action and suicide comes to be perceived as a logical solution. Some research suggests psycache to be a strong predictor of suicidality, even ahead of factors like hopelessness and depression (Verrocchio et al., 2016). Baumeister's (1990) theory, in contrast, describes how an individual becomes aware of aversive feelings of failure, which promote self-hate, where completed suicide comes to be seen as a way out from painful self-awareness. Here suicide can be seen as an ultimate escape route from the self and the world.

While these kinds of theories help to explain some of the dimensions of suicidality, they are less instructive concerning the inter-relational elements which inform the process of moving back and forth from suicidality. Van Orden et al (2010) proposed an interpersonal approach to suicide focusing on the dimensions of 'perceived burdensomeness' (liability to others and self-hate) and 'thwarted belongingness' (loneliness and lack of reciprocal caring relationships) (Van Orden, Merrill, Joiner, & Thomas, 2005). When these two states are present and experienced as unending, hopelessness can promote suicidality as an option. Joiner's (2005) interpersonal-psychological theory of suicidal behaviour proposed that an individual will not die by suicide unless they possess both the desire to die in this way, and the means to achieve that outcome. However, this process need not inevitably lead to suicide.

*Gendering male suicidality*

Scourfield (2005) points to the limitations and ambiguities within extant theory and research

around gender and suicidality, such as adopting binary constructions of male/female as if these two groups were homogenous entities, and neglecting power dimensions in gendered suicide. Gender as a construct itself is far from straightforward, but is best understood as fluid, and as constructed through everyday actions and discourse (Ridge, 2019). For Connell (1995), masculinities are developed in local social worlds, where expectations concerning 'hegemonic masculinity' are authoritative, governing any given locale at any particular time as the proclaimed idealised (yet unobtainable) male state. Inevitably other forms of masculinity operating outside this hegemony are 'marginalised' and/or 'subordinated.' 'Multiple' masculinities then emerge and compete for normative status. Connell's (2005) theory as applied in men's health research has received criticism for encouraging a structural focus that neglects the subjectivity of men (Jefferson, 2002). Nevertheless, it continues to be widely used in interpreting qualitative research. Drawing on Butler's work on gender as a performative (2004), Jaworski (2014) critiques current understanding of gender and suicide and its embeddedness in a socially constructed knowledge. She points out how the 'gendering' of suicide, such as by framing suicide attempts as 'successful' and 'failed,' mirrors a binary distinction that interprets suicide as male rather than female, active rather than passive, and resistive rather than fatalistic. When Jaworski refers to the term 'masculine', it is in the sense of normative performances by the male gender, and it is in this sense that masculinity is deployed in this paper.

Empirical literature on male suicide is considerable but has only in more recent times included qualitative studies. Here, the social and cultural context in which suicidality occurs is of importance. Based on data showing an increase in premature male death in the ex-Soviet Union, Moller-Leimkuhler (2003) proposed that men struggled to adapt to non-traditional roles related to high unemployment and social change, while social isolation and powerlessness increased high risk behaviors and suicide. Brownhill and colleagues (2005)

described a ‘big build’ of emotional distress where men could step ‘over the line’ towards suicide. Cleary’s (2012) qualitative study of Irish men who had seriously attempted suicide close to the time of the study, identified hegemonic cultural norms concerning masculinity as discouraging disclosure of emotional vulnerability. Instead, participants turned to means like alcohol or substances to cope, therein exacerbating and prolonging their distress. Rather than disclose their distress and get help, these study participants had opted for suicide. While some commentators consider suicide as indicating a crisis in masculinity, this idea is controversial, as it can overstate the extent of social change, and each generation is anxious about masculinity in turn (Scourfield, 2003).

In terms of countering suicidality, Oliffe and colleagues (2012) suggested that men capitalise on specific gender dynamics like fathering/protector roles and recast help-seeking as a rational choice, thus masculinity can be a means of moving away from suicidality. Getting help from respected others, making links with others, re-casting help-seeking as masculine behaviour, and better regulating emotions all have the potential to disrupt suicidal processes (Struszczyk et al. 2019). Other studies suggest that gaining a deeper understanding of distress may be important for sustainable recoveries. Where depression is severe in men, two main countering responses to suicidal ideation may operate: ‘connecting with family, peers and health care professionals and/or drawing on religious and moral beliefs’ (Oliffe et al. 2012, p. 506). Conversely, family dysfunction and estrangement, not fitting in at school and work, health care alienation, and a sense of being a burden on society all contributed to men’s sense of social isolation (Oliffe et al., 2019).

In summary, many studies have sought to explain male suicidality, but fewer have specifically explored mens’ accounts of stepping back from, or conscious avoidance of death. Building on work by Oliffe and Colleagues (2012), we also believe there is potential

to learn more from non-clinical samples of men, as this may present interesting contrasts to men with diagnosed mental illnesses. By analysing the accounts of men regarding suicidality (and the conscious moves away from it) we aimed to capture the affective and social dimensions of this complex and enduring issue. A prevailing normative issue we explore in this article is the gendered challenges facing men, which indicate the enduring strength of reductive masculine cultures and their interconnectedness, the importance of social relations and gendered performativity.

## METHODS

### Overview

The project described in this article was conducted in partnership with a UK charity, all participants were registered with CALM (Campaign Against Living Miserably), a charity dedicated to preventing male suicide e.g. via a telephone helpline. The project took a qualitative approach, using one-to-one interviews with 11 men to gain insight to their experiences of distress, and how men subsequently moved away from suicidality. The focus was on deeply understanding suicide-related narratives of men (Riessman, 2008).

### Recruitment

Participants were men ranging in age from 23 to 50 who self-reported past serious suicidal thinking and intent, but who ended up not following through with an actual attempt at taking their own life. Recruitment was through the CALM charity database, indicating that participants had been sufficiently motivated by their experience to reach out to a charity for help (all participants had confirmed their interest in participating in research). Two hundred men were sent an email by the CALM administration to introduce the study, along with researcher details, the participant information sheet and informed consent form (the study was approved by the Ethics Committee, Department of Psychology, University of Westminster). Participants who responded to the

researcher were contacted to check for eligibility, and if so, to arrange a suitable date and time for the interview, in a place that was most convenient for them (see below). We excluded men with potentially fatal suicide attempts that were not intentionally avoided, as we were interested for this study in men who knowingly stepped back from suicide, not those who by chance avoided it. Of the 20 men who contacted the researcher by email, nine were excluded due to current distress (n = 3), self-reported potentially fatal suicide attempt (n = 2), or were lost to follow-up (did not respond to multiple email contacts) (n = 4).

A final total of 11 men (Mean 37 years) were included in the study; ten participants were white and one was Black, and all were British and currently residing in the UK. Two participants were married and five were in a relationship at the time of the interview. One participant self-identified as bisexual and another as gay. Based on the men's accounts, seven were in full or part-time employment, one in full-time study, and three men unemployed. Employed men worked in various industries including IT, business, media, sales and the charity sector. All participants apart from one had been medically diagnosed with depression and/or anxiety disorders previously, and three men also presented with multiple mental health issues, including self-harm, experiences of psychosis or obsessive-compulsive disorder. All participants self-reported suicidality (serious thoughts, plans, and up-to and including attempts in progress), but did not purposefully carry out an attempt.

**Data collection**

Suicidal episodes are necessarily time limited episodes, and have a beginning, middle and end. Thus, we used a narrative interview approach (Riessman, 2008), encouraging

participants to engage in story telling to capture deeper insights into how participants construct their social worlds. Interview questions were aimed at eliciting the participant's story surrounding suicidality in their own words. An interview schedule was developed by the first and third author, the latter of which carried out all of the interviews. Interviews aimed to elicit the participant's story around their suicidality in their own words, with the participant starting their narrative at any point in their lifetime. All questions were open-ended, and referenced the time before the most recent distressing episode started (leading to suicidality) e.g. 'What was going on before you felt that things weren't quite right?', the descent into distress, the distress itself, and subsequent events. Subsequent questions exploring parts of the participant's story in greater detail and were guided by their responses. A topic list was referred to if certain areas of interest had not been covered, including turning points; recovery (or not); sense of self; everyday life (work, relationships, social life); support strategies and reasons for not following through with a suicide attempt. All interviews were conducted in private locations, including at the University of Westminster, library rooms, health centers close to where the participants lived, and one at the participant's home. Interviews, lasted between 40 and 180 minutes (with an average of 120 minutes) and were audio recorded with the participant's consent, then transcribed verbatim by the third author. Due to the highly sensitive nature of the interviews (and potential for the extensive narratives to identify men involved), data from this study has not been made available to share.

**Data Analysis**

We collected narratives, but mainly relied on an inductive thematic analysis to analyse participant accounts. Our focus was on seeking out patterns and shared meanings across

the data set, i.e. themes (Braun and Clarke, 2006). Initially, HS developed an overview of each participant's story as a whole. Hard copy transcripts were read and re-read by this author (and a sample read by DR), to comprehend the overall narratives, and prepare for the thematic analysis. Transcripts were analysed and coded for themes by HS, initially manually line-by-line, then more broadly, with first author assistance who helped select and refine the themes. Codes that appeared consistently were identified and formed a list of provisional themes (for example, 'childhood trauma'). These themes were compared and grouped according to similarity, creating overarching themes that were dominant in the accounts (for example 'life before' distress). Themes were developed by moving back and forth between the data and the literature around the topic areas. Subsequently, DR drafted a first draft of the journal paper, which was then debated and added to by the authors over multiple revisions, iteratively. AF then further developed the analyses in the paper, paying careful attention to participants use of words and (gendered) metaphors within their accounts, and the meanings participants ascribed to their feelings and experiences. Finally, the paper was edited by the authors in the light of a broader literature (e.g. men's mental health). In order to ensure anonymity, we have not identified the ages or circumstances of the men, except for the information provided above.

## RESULTS

### *'Left behind by life'*

Participants in this study described a range of childhood experiences, from idyllic (e.g 'the sun was always shining' (Will)) to one severely lacking in love and affection ('we never felt wanted' (Mike)). At some point however they had each arrived at a point where they reported a lack of success with life in various ways. Paul, for example, explained how in late adolescence he had little direction:

> I just felt left behind in life, I felt I lacked life skills. I had friends who were doing things, driving [pause] just doing certain things and talking about certain things and I remember thinking, why am I so far behind in all of this….my friends would have a bit of direction….and eventually they would move onto that, it would blow my mind….[I felt] a bit of a let down if you like…I just expected more of myself…I had so much more potential, so much more to do and give- and yet I was struggling.

There was an underlying sense that others (especially men) appeared to have a sense of purpose, whereas being unable to identify or focus on what it was that they wanted to do in life, had led to a sense of disappointment and underachievement for participants, e.g. 'I was always kind of looking for something that was unattainable (Henry).' Comparisons were drawn with others who, on the surface, seemed better connected and more successful. Henry gave the example of how other people on the commute into London who. 'would be going to work in the City…. suited and booted…. And I would look around the carriage and I just wouldn't feel part of it.' The quote below describes Mike's frustrated attempts to gasp the essence of a valued masculinity for himself:

> It all stems from the point of being, what does it mean to be a man, and a dad and a masculine figure, what am I supposed to be like, what am I supposed to do? I've always had very, very masculine jobs, I've been military, I've worked in warehousing…so very masculine…What's that all about you know?

This focus on one's performance as a man in society resonates with Jaworski (2014) in terms of gender norms around success and failure inherent in masculinity and male suicidality. Men's evaluations could lead them to compare themselves negatively to

others, creating feelings of envy and jealousy, which could compound their suffering. Jake recalled how when he wrote a suicide note to his brother, 'I was jealous you know, just because he's got everything that I want.' This sense of having little or not enough in life, for Jake had extended to his job and relationships. Jake explained how after he became unemployed and his partner left he believed he was left with nothing. Jake's separation from his partner had resulted in homelessness and sleeping on friend's floors, compounding his sense of failure.

Part of the sense of inadequency stemmed from expectations of being financially adept and a breadwinner. Chris's redundancy at work led to growing debt as he struggled to pay his mortgage, and to the realisation that, after 30 years, he was neither the breadwinner nor a manager at work. Anger was not only directed inwardly, others were also blamed for the situation he found himself in. When he couldn't find a job, Chris described how he 'felt angry that they'd done what they'd done to me, and how they did it…And well now I'm worthless [and] can't get a job.' Ben expressed a similar sense of injustice in regard to his relationship breakdown:

> It was just that shock because I didn't see it coming, I didn't see how this was happening because we were solid as far as I was concerned…we'd had conversations about a you know marriage and a future together and had been mutually happy…Her parents split[ting] up had a part to play in it…but then that just makes me angry if that's the case cos that's just [pause] really fucking unfair.

*Retreating and reaching out*

Hiding one's self away from, or within, society emerged as a prominent theme in all the men's narratives. Participants spoke of becoming increasingly isolated, while

acknowledging that their introspection contributed to negative and self-destructive rumination. Nevertheless, initial retreat from others and their lives can provide short-term comforts. Henry would, 'close the curtains and feel kind of safe….it's just the sense that you don't want to face the world.' In a fragile state it seemed easier to get on with it alone.

Some men did socialise while struggling, however this involved putting on a front. One common coping strategy was alcohol which, in addition to giving an outward appearance of coping, could help to take away the inward pain; '[when] drunk and giggly [with friends]…it [felt] normal'(Simon). For others, putting on a mask to socialise could feel inauthentic. Will adopted different personas, copying other's behaviors to 'look good and fit in.' Still, he was unable to escape the feeling that he was being dishonest with people, and this ultimately left him with feelings of shame.

Some of this hiding away stemmed from the shame associated with seemingly unmanly displays of emotionality during times of distress (e.g.'[It's] ridiculous, I'm a grown man behaving like a child'.) Revealing one's fragility to others could feel humiliating. Will explained how he felt a mixture of shame and resentment at having to return to the safety of the family home during a breakdown:

> It was very humiliating…you know to have your mum take you home when you're from an adult community, um, I just did my best to block it off but that just added to the feeling of I should just go away and kill myself.

Despite discomfort with emotions, their appearance was inevitable; Craig described regularly crying in the toilet at work, while Paul broke down in front of his wife. Rather than

being seen as having a use, emotional outbursts were regarded by Paul and others as ‘not very constructive.’

Despite some reluctance to do so, men in this study, for various reasons either found they had to, or chose to, disclose their distress to professionals at work or in health settings, but there were mixed experiences. Henry for, example, felt let down by his conversation with a female manager which seemed emotionally disconnected:

> She said all the right things you know, according to the HR [human resources] handbook…[but] her subsequent actions suggested that actually she was just going through the motions….she was kind of listening but not caring….that empathy and kindness didn’t shine through at all.

Similar feelings were expressed by Paul when he’d tried to talk about his feelings with a GP during an appointment for a hernia; ‘I said to him, oh there’s actually another thing, he actually huffed and said you know we only get fifteen minutes per patient, so I never told him.’

Some of the shame for participants was in having to disclose, including to themselves, that they had a psychological condition. When Mike was prescribed antidepressants, his instinctive response had been, ‘I’m not a schizophrenic or anything.’ Henry had felt shame in the pharmacist knowing about his problem when collecting his prescription because of how being on medication marked him as having a mental health problem. One particular anxiety was how the label of a condition could besmirch their identity. Paul conceived of such labels as a permanent markers of stigma and shame, ‘I was always reluctant to diagnose anything because I thought to myself, as soon as you give it a label that’s when

you've got it for life.' Both Mike and Craig were employed in conventionally masculine industries, Mike as a policeman and Craig a mechanic. Mike described a colleague not getting a job because others were aware of his psychological problems, arguing that this is the reality of the world in which he lived. Chris needed disability benefits, and believed that others would not understand his benefits, such as his blue disabled badge that allowed him to park closer to desired destinations when driving.

*'In the trenches'*

Suicidal thinking was not straightforward within men's narratives; conflicting thoughts and feelings were expressed toward the act itself. However, at some point in their suffering, men perceived their life choices as diminishing towards suicide. Here, there was a sense that there was no future in living this way, as Jake explained:

> It became ab-absolutely just a horrible feeling of not being able to have any future…I just couldn't go on and the only way to go was I can't go on like this I just don't want to, I just want to die….you're going to have to kill yourself.

These conflicting thoughts and feelings around suicide were frequently expressed through military metaphors, e.g 'It's a sort of war, it's almost as if you're two people and, I don't know, the moral guy's not quite as strong….the other one's always going to win'(Craig). Mike described his suicidality as being 'in the trenches.' Here the metaphor of war conveys both the enormity of the internal struggle, and also the normatively masculinised portrayal of suicide as a battle ground (between life and death), including militaristic beliefs around cowardliness and heroism, success and failure.

The means used to self harm could be rapid or slow. At one point, Paul would consume a

whole bottle of alcoholic spirit every night, 'I used to lie there and just beg that I wouldn't have to wake up.' Others focused on the practicalities of suicide, such as researching the weakest points in a car, so as to ensure an attempt ends in death.Taking some control in this way was juxtaposed with feelings of helplessness and vulnerability while in distress. Ben talked of suicide as taking 'some action that's mine…I couldn't get a grip of anything….and that would be something that would be my choice, as something I could do'. Thoughts of suicide gave some men a sense of being able to achieve something. Certainly, the decision for suicide could provide clarity, and Jake 'was at peace really because I'd made this decision', which could contrast with the chaos of distress. In instigating his suicide attempt, Mike described the point at which he put the belt around his neck as a moment of serenity:

> I was calm as I was sat in this chair, calm, that was what scared me the most looking back at it, how calm I was. I wasn't upset, I wasn't distressed, I wasn't in any of that, I wasn't in a crisis, it was calm as cola…

Nevertheless, there could be ongoing confusion at the time about whether suicidal thinking was logical - 'a valid option because that was a solution to a problem' (Tim) - or illogical.

*'The fight back starts'*

While all participants self-reported suicidality (serious thoughts, plans, and up-to and including attempts in progress), they had purposefully stepped back before an actual suicide attempt. While this stepping back proved, for most men, hard to put into words, some spoke of 'turning points,' characterized as moving away from suicidal thinking and toward recovery. Significant moments were typically: realising that they had control of their own fate, gaining an understanding of their distress, initiating meaningful life change, and connecting with others. Masculine framing was also used to conveyed how the men seized

control of their recovery. Here, recovery was framed as arduous, demanding of resilience and courage, and a heroic act to reconstruct a strong and healthy self. Such changes could be sudden or more protracted. Mike framed a defining moment as 'the fight back starts', but for Paul, this 'wasn't an overnight process at all, I was still suffering.'

Despite the fighting talk, ironically strength could be gained by finally admitting their vulnerability, although even this fragility could be framed in masculine ways, e.g. as rational or as active: '[I]picked up the phone to the GP because it felt like the logical thing to do.' (Tim). When asked why he first visited the doctor, Jake replied instrumentally, 'I don't know….just took myself there….dunno [pause] just did.'

Interestingly, some men were inclined to explore the conceptual side of their recovery, by looking into the literature behind it; 'It did interest me what was going on in my mind…I really did just want to…repair the damage' (Will). Autonomous approaches to recovery also fitted with masculine norms, and could include, for example, mood diaries, researching books, and 'serious articles' in the media and on the internet. However, some acknowledged that having an overly-analytical mind was part of the problem. Alternatively, connecting with another person through therapy was seen by some as the key way of sorting through their mental chaos, as Paul explained:

> The way I described it to him [the counsellor] at the time was imagine having a load of jigsaw pieces just flying around in your head or just being flung around day to day, no real picture…it never really made sense. And that counsellor at the time just made sense of a few things, showed me which ones to disregard.

Others found a sense of connection via listening to music where the artists involved had

gone through similar struggles. Some like Will found meditation to be helpful for letting go of past hurts and recovering from suicidality:

> I feel a lot more relaxed. I do meditation…and I don't worry about the past anymore you know I've been able to do a sort of [pause] do a stock clearance of myself and you know I've got the knowledge….I stopped feeling suicidal [pause] I don't think about myself so much now.

Men were divided over the role of medication in recovery. Most men in this study had been prescribed antidepressants at some point, and some described benefits including feeling calmer. Others though were skeptical about the long term benefits of medication. For Henry, medication alone was considered insufficient to penetrate into the complexity of his distress as he considered it a passive response rather than an active search for the root causes of his problems:

> I think people can sort of by-stand and let or hope the drugs do the work for them, and don't take any action into actually getting to the bottom of it, and that was me….[since therapy] I'm really just sort of taking a holistic approach to it as opposed to you know, just popping the pills and hoping it'll go away (Henry).

Another tactic for recovery from suicidality was to re-focus one's attention on positive wellbeing or positive recovery messages. Some had found it useful to contemplate the universal (rather than personal) nature of suffering, thus coming 'to terms with life's not [being] fair' (Tim). Some men learnt not to compare themselves to others as much, so Mike no longer believed, 'my gold bar has got a black spot, why doesn't his have a black spot?' For other men, there was a realisation of life's uncertainties, admitting their lack of control

over things, and how ‘letting it happen, we are emotional beings, emotion is a good thing’ (Mike).

As to why men did not follow through with an actual suicide attempt, men gave a range of reasons, including moral issues and fears such as about the pain of death. Despite the better outcome, stepping back from suicide could be constructed in masculinised terms as an act of ‘cowardice’. Jake explained how he had changed his mind about setting fire to himself when the realisation hit that it was going to be too painful for him to endure, and Paul remarked that he didn’t have the ‘balls’ to kill himself. This masculinised portrayal of suicide as an heroic act was most clearly advanced by Henry who described it as, ‘singularly the most brave thing anyone can do’, while identifying himself as not bave enough to carry it through.

While relationships had played a role in mens’ accounts of suicidality, they were also key in their stepping back and moving away from it, promoting a more positive sense of self. Ben had come to a final realisation that he was, in fact, loved and cared for. He also wanted to protect others from the suffering his suicide would inevitably cause them, e.g., ‘there’s probably some people who would never get over it’. Jake talked of the sacrifices that others had made to care for him, describing suicide as ‘kind of throwing all their help in their face.’ For three of the men, being a father was significant, and they wanted to guide their children and set a positive example. Paul described how his daughter ‘saved his life’, and Jake, in a moment of near-suicidal action, imagined his son was there ‘quite prominently his face.’

The role of fatherhood, however, was complex in suicide. Mike described his children as ‘the only anchor I’ve got to this world,’ but during a near-suicide attempt he described a more mysterious motivation not to go through with the act:

> There was no voice in my head or visions of my children…or I'm depriving people...just [clicks fingers], stopped completely, took the belt off [from around my neck], put it away and that was it.

Jake often called his son his 'protective factor', but said of a time he almost attempted suicide, 'I have to kind of protect *me*', and this thinking had taken precedence over everything else. Ben and Craig discussed the same moral conflict, and expressed an underlying resentment that their responsibility to others had taken away their choice to take their own life.

Connecting with others was an important counter to the sense of isolation and/or abandonment that infused participant narratives and thwarted recoveries. Some men found support through medical help; both Mike and Chris were grateful to health professionals who showed kindness that appeared to go beyond the call of duty. When Chris was ill, he noted how he was treated well by consultants and felt like he fostered friendships with the nurses, who 'couldn't do enough'. For some, a catalyst for recovery was an intimate connection with another individual where men felt seen. Luke describes this with his colleague, '….the fact we kind of shared our experience about it meant that it felt less judgmental.' Often, recovery necessitated a reconsideration of the self. Mike, for example, believed he had to stop resisting the notion of himself as vulnerable to mental illness, as well as his dependency on the help of others:

> I've never called myself ill, I've never called myself a victim and I've never called myself as being um needing help if you like. Those are the three things that I've never really wanted. But in effect that's what you really are, and when you're forced to face that actually yeah, you are ill, you are a victim, and you do need help.

Many men described the emotional openness, security and positivity of their relationship with their therapist as being important in their recovery. Men also harnessed their experience of distress to help others in a way that also helped themselves: 'if I can have an understanding that I could help someone else….that would actually make me feel better' (Chris). While recovery from mental health problems is known to be provisional in nature, and may even seem to the individual to be going backwards at times (Davidson, Lawless, & Leary, 2005), all men, without exception, expressed sentiments that 'it's only when you speak to someone who gets it, that it makes a difference'.

## DISCUSSION

This study explored how men construct the process to suicidality and back again. Their accounts suggest a journey toward and away from suicide (rather than an end point), of which stepping back at the last moment is just one possibility, and where broader recovery options are also available. Stepping back or recovery are not some sort of discrete end points. Rather, they are linked processes in suicidality, which raise the possibility of abrupt turning points (e.g. not having the 'balls'), as well as longer-term recovery processes (e.g. via recognition through therapy) in suicidality. Our results highlighted the frequent use of masculinised language and metaphors (Jaworski 2014) to describe male experiences around suicidality, e.g. waging war against both themselves and the world, bravery and cowardice, success and failure. We have used men's own language and metaphors as a means though which to frame their accounts, e.g. left behind by life; in the trenches and fighting back. Interpersonal dimensions of suicidality particularly featured in the accounts of our participants also, e.g. relationship problems as contributing to suicidality, the problem of frustrated attempts at reaching out for help, and the importance of connection and having others recognise their suffering without judgement for recovery. Our study also noted how

solitary activities (but included elements of how participants related to themselves) could be understood as contributing towards recovery e.g. practising mindfulness, journal keeping, and listening to music.

Inspite of greater awareness in society, taboos and difficulties in discussing suicidality persist (Chapple, Ziebland & Hawton, 2015), and participants judged that they had failed, including as men. As emphasised in our study and the literature cited in this paper, men's experiences of suicidality are gendered. In line with notions of competitive masculinities (Connell 2005), men in our study were highly attuned to comparison, perceiving their performances in life leading up to suicidality as unsatisfactory, with missed opportunities and disappointments in careers and relationships highlighted. In this sense, gendered relations intersected with other intersubjective dynamics (like loneliness and shame) to offer up a set of pernicious conduits to suicide.

To date, little research has touched on the affective relationality of suicide. Emotions are usually considered as individualised (e.g., lack of competence in dealing with shame) (Rasmussen, Haavind, Dieserud, & Dyregrov, 2014), rather than in terms of their inherently relational nature. In this study, men's relationship with their own emotions was a troubled one; they chastised themselves for expressing certain emotions (or too much of them), and in times of distress many times preferred to hide themselves away from others, rather than face the shame of revealing their vulnerability to others. Sometimes, disclosure to professionals (e.g. workplace, health service) had not been met with the understanding or empathy they sought, which could amplified feelings of aloneness, shame and burdensomeness. Here, it is clear that feelings like shame are individually experienced but collectively produced, and inflected by gendered norms as part of a wide array of social expectations and normative constructs (Ahmed, 2013).

It is argued that shame tends to become a maladaptive affective state in highly individualistic societies, since it necessarily emerges in relation to externalized standards, which can collide with personal needs (Wong & Tsai, 2007). As our study suggests, there are still taboos around mental illness and suicidality, and certain responses are thought to especially reflect on manhood (such as perceived 'failures', weaknesses, giving-up). In this sense, shame becomes an important part of the collective production of suicidality – it both emerges from a cultural disposition (to do with such things as death, productivity), from the perceptions of individual acts (of 'weakness'), and is an interpersonal form of exchange (e.g. as in the shame of being recognised as having a mental health problem by professionals such as employers or pharmacist). This suggests shame to be an important intersubjective experience of relevance to these men's mental health, and thus having at least indirect links to suicidality.

*Stepping back from suicide*

While stepping back from suicide needs to be understood in a wider framework of recovery (rather than just stepping back in a moment of crisis), many men were able to partially explain their reasons for not following through with suicide as an action. Reasons here included fear of pain or dying, a sudden recognition of inflicting pain on others, or even as not being masculine enough e.g. not having the 'balls'. While poor or disrupted relationships were part of the narratives of the journey toward suicide, positive aspects of relationships (e.g. with family, professionals and children) also provided motivations to live, and even arose abruptly to be prominent considerations during the act of suicide. Through such connections, men could feel that they were somehow seen, understood, needed or otherwise emotionally involved, and such inter-relatedness could act as a tonic. Varying

emotional connections with others were also identified in other studies as a vital strand of the suicide prevention and/or recovery process (Emslie et al., 2006; Struszczyk et al., 2019).

Professionals play a critically important role when they can develop ongoing interpersonal connections with men, that demonstrate non-judgement and a keen interest in their stories, as well as an understanding of what men have been through (Jordan et al., 2012). Men receiving help from trusted and admired individuals in an informal setting, along with recasting help-seeking as a masculine endeavour, can also be a key to the prevention of male suicide and the promotion of recovery (Struszczyk et al., 2019). We note how discourses around recovery could be less masculinised than those concerning suicidality in our study, with the recovery process framed as more challenging of hegemonic masculinities e.g. being vulnerable with a therapist, identifying as a 'victim', or taking up of meditation (Emslie et al., 2006).

What is interesting and important for interventions, is the paradoxical logics of gender, whereby recovery is in turn constructed as weakness, strength and potency. It is here – in the seemingly conflicted sites of the sociality of suicidality – that we gain access to the 'habitus' – the realities and dispositions (Bourdieu, 1977) – of suicidality, which connects to broader moralities (to not give up), individual affect (suffering), and relational dynamics which shape feelings (e.g. dependency). Both suicidality and recovery thus become individualized, relational and 'held up' by particular social structures (like normative masculinity). In seeking to understand the habitus of suicidality, it is useful to think about the rationale that underpins this relational action. Much of the suicidality presented by participants was embedded in long-term suffering, and in this context, taking one's own life could come to be percieved as having an internal logic (Ridge, 2008), that develops to a point that it appears the only choice (Cleary, 2012). While men could search in vain for psychological relief,

suicide was conceived of as an ultimate escape. Similarly, the men in Emslie et al.'s (2006) study also described the option of suicide as providing comfort. This is also documented in Oliffe et al.'s (2012) pathway between depression and suicide, and reflects Shneidman's (1998) concept of 'psychache' (unbearable pain).

Some men saw suicide as an escape from self-hatred (Baumeister, 1990), and self-hatred is also a risk factor identified in the interpersonal model. Supporting other qualitative results, suicide was perceived as a way of gaining control (Cleary, 2012; Emslie et al., 2006; Redley, 2003), or even as being a benefit to others, reflecting Durkheim's (1951) 'altruistic suicide', where an individual values their own self below that of the collective. These logics of practice, as it were, are important to unpack in terms of understanding suicidality from the subject position of the person. In turn, a deeper understanding of these logics of practice reveals how seemingly irrational acts make sense in the moment (or moments) of intense suffering and relationality (or lack there of).

In conclusion, it is noteworthy that notions of manhood wove through interpersonal accounts of suicidality, to create certain vulnerabilities to suicide, and were then in turn transformed by the logics of 'turning points' in recovery. It was interesting that these sites of sociality were both inflected by gendered practices, and other kinds of social dynamics, including the moralities involved in recovery. While men were not always sure why they had sought professional help, participants frequently (but not always) narrated their recoveries in terms that resonated with masculine ideals (e.g. courage, persistence), but also as a moral fortitude that articulated the relationality of recovery. That is, the return to productive citizenry, and the potent individual who can fulfil the requirements of a productive life. Ultimately these accounts of suicidality have productive, normative and relational qualities, illustrating how 'recovery' draws together the personal, social and the moral. Our empirical study

underscores the need to reframe gendered norms around suicide as part of prevention (Jaworski, 2014). It highlights the problematic nature of men categorising suicide in masculinised terms (as in active passive, success/failure, logical/illogical), suggesting that these ways of thinking could be challenged, and that the relational elements of recovery be better illuminated and supported. This way, men can discover better ways of thinking about and working through their times of distress.

*Study limitations*

This was a small-scale study which featured men who had sought help via a suicide helpline. As around 1 in 10 eligible participants responded to our invitation for the study, we cannot be sure we have captured all relevant experiences. For methodological and ethical reasons, men who had made an actual serious suicide attempt and who were currently experiencing distress were not included. Our principle concern was conducting a careful interpretive analysis of rich data, and where this is the case, fewer but longer interviews are considered essential in order to develop new conceptualisations around a topic (Morse, 1995). For future studies a comparison between men who are chronically suicidal and those such as in our sample who appeared to be in recovery, would be helpful in order to see which issues might differentiate the two groups.

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