Exploring the relationship between male gender, male psychology, and male suicide risk and recovery.

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Abstract

Background

Globally, one of the most consistent facts about suicide is that men are more likely to die than women. In the United Kingdom, suicide is the leading cause of death among men under the age of 50. The magnitude of the male suicide crisis demands urgent investigation into its causes and strategies to reduce its prevalence. Despite the persistent gender disparity in suicide rates, there has been limited research specifically focused on male suicide, and even less exploring the relationship between male gender, male psychology, and suicide. This thesis undertakes preliminary, exploratory study research to enhance our understanding of how gendered aspects of male psychology may intersect with male suicide risk and recovery. The objective of this thesis is to generate new knowledge and propose hypotheses regarding potential phenomena associated with male suicide risk and recovery. As such, this thesis has four overarching aims: 1) Conduct basic, exploratory research to advance our understanding of male gender, male psychology and male suicide**;** 2) Develop our understanding of the psychological pathways underpinning male suicide risk and recovery factors, including potential psychological distinctions between proximal/distal risk and potential psychological distinctions between men with thoughts of suicide and men who have attempted suicide; 3) Explore the barriers men who are suicidal experience in seeking professional support; and 4) Develop an agenda of research priorities to guide the next iteration of male suicide research.

Methods

This thesis is comprised of 4 empirical chapters. It begins in Chapter 3, with a systematic review and meta-synthesis of qualitative literature, conducted to investigate male suicide risk and recovery factors (N = 78 studies). Chapter 4 was a global cross-sectional study to explore psychosocial differences between men who have attempted suicide, men with suicidal

ideation and men with no suicidal history. Chapter 5 was a qualitative thematic analysis of the barriers men who are suicidal experience in accessing professional support. The thesis concludes with a Delphi study (Chapter 6) working with lived experience experts to develop an agenda of research priorities to progress the field of male suicide.

Results

Findings from Study 1, the systematic review, revealed a potential association between norms of masculinity and suicide risk in 96% of studies. Masculine norms related to male emotional suppression, failing to meet standards of male success and the devaluing of men's interpersonal needs appeared to 1) increase men's psychological pain, and 2) diminish men's ability to regulate that pain, which we suggested elevates distal/proximal suicide risk. Findings were synthesized into two novel models to help better understand male suicide risk and recovery, the '3 'D' Model of Masculine Norms and Male Suicide Risk' (3 'D' Risk) and '3'R' Model of Male Suicide Recovery' (3 'R' Recovery). We made 22 recommendations for future male suicide research and 7 recommendations for theoretical exploration.

Findings from Study 2 suggested that dysregulation in the domains of emotions, self and interpersonal connections increased progressively between men who are not suicidal, men who have thoughts of suicide and men who have attempted suicide. Findings indicated that higher levels of loneliness and having a mental health diagnosis (MHD) increased the odds of suicidal ideation category membership compared to controls. Higher levels of having a MHD, and being non-heterosexual increased the odds of suicide attempt category membership compared to controls. Finally, higher levels of financial strain, having a MHD, being non-heterosexual, more restrictive attitudes to emotional expression, and lower levels of mattering to others, increased the odds of suicide attempt group membership compared to suicidal ideation.

Findings from Study 3 emphasized the significance of exploring how male gender interacts with men's help-seeking behaviours. The cultural suppression of men's emotions appeared to contribute to a lack of psychological capacity within some men to seek and utilize support. Some men perceived help-seeking as socially transgressive which is potentially linked to societal expectations for men to exhibit strength and suppress their pain. Masculine norms of self-reliance meant some men appeared to prefer to self-manage their distress. Concerns

about potential negative consequences of seeking help - such as hospitalization - seemed to weigh heavily on the minds of men experiencing suicidal despair and who felt conditioned to maintain control and achieve success. Based on our findings we made 21 recommendations for services and public health messaging to increase men's help-seeking behaviours.

Study 4 utilized the expertise of 242 lived-experience suicide experts and 10 international academic/clinical male suicide experts to develop a research agenda of 22 priorities for male suicide work. Questions related to ten thematic domains: 1) Relationships with others, 2) Relationship with self, 3) Relationship with emotions, 4) Mental Health, 5) Suicidal behaviours, 6) Early life experiences, 7) Structural challenges, 8) Cultural challenges, 9) At-risk groups, and 10) Support and recovery.

Conclusion

This thesis contributes four empirical studies to the male suicide evidence-base, including one of the first literature reviews of its kind - a qualitative meta-synthesis and systematic review of male suicide risk and recovery factors - as well as a cross-sectional, qualitative, and modified Delphi study. From these studies, eight recommendations for male suicide theory development and 60 recommendations for future research, prevention, and intervention are made. Male suicide rates indicate that certain men face profound challenges in accessing a fulfilling and meaningful life. Our research findings emphasize the importance of adopting a gender-sensitive approach to suicide prevention and research that acknowledges the impact masculine norms may have on male behaviour and how male distress is perceived and addressed by others. Given the complexity of male suicide, interventions may be necessary at various levels, ranging from individual men to cultural shifts. It is crucial to approach this work without demonizing or pathologizing masculinity. Instead, the insights gained from this thesis suggest that enhancing our understanding of cultural norms of masculinity and how they may increase some men’s exposure to psychological pain, their tools to regulate that pain, and how that pain is read and responded to by others, are potentially critical.

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Bennett, S., Robb, K. A., Zortea, T. C., Dickson, A., Richardson, C., & O'Connor, R. C. (2023). Male suicide risk and recovery factors: A systematic review and qualitative metasynthesis of two decades of research. *Psychological Bulletin,* 149(7-8), 371–417. https://doi.org/10.1037/bul0000397

Bennett, S., Robb, K., Adán, R., Zortea, T., & O'Connor, R. (2023) *"Exploring psychosocial factors that distinguish men who have attempted suicide from men with thoughts of suicide and men who have never been suicidal. Findings from a global cross-sectional survey."* [Manuscript submitted for publication]. Suicide Behaviour Research Lab. University of Glasgow.

Bennett, S., Robb, K. & O'Connor, R. (2023) *Male suicide and barriers to accessing professional support: a qualitative thematic analysis.* [Manuscript submitted for publication]. Suicide Behaviour Research Lab. University of Glasgow.

Bennett, S., Robb, K. A., Andoh-Arthur, J., Chandler, A., Cleary, A., King, K., Oliffe, J., Rice, S., Scourfield, J., Seager, M., Seidler, Z., Zortea, T. C., & O'Connor, R. C. (2023, September 7). Establishing Research Priorities for Investigating Male Suicide Risk and Recovery: A Modified Delphi Study With Lived-Experience Experts. *Psychology of Men & Masculinities.* Advance online publication. https://dx.doi.org/10.1037/men0000448

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Of all the dreams I have held for my life, a PhD was never one. Similarly, seeking to understand the pain in men was not something I would have anticipated consuming so much of my existence. How did I end up here? I am not sure. Nonetheless, here I am, and being here has taught me so much, and for that, I will always be grateful.

This thesis is dedicated to Liam and Jonathan.

Authors Declaration

“I hereby declare that I am the sole author of this thesis, except where the assistance of others has been acknowledged. It has not been submitted in any form for another degree or professional qualification.”

Susanna Bennett
September, 2023

Chapter 1: Introduction

The purpose of this thesis is to explore the relationship between male gender, male psychology, and male suicide risk and recovery. This chapter introduces the phenomena under investigation - suicide in men – and will briefly explore the male suicide crisis, the historical context of suicide, its scientific study, and the methodological approaches that have dominated the field to date - their merits, shortcomings, and gaps in the literature. Next, key psychological theories related to suicide and masculinity will be introduced together with a summary of what the existing evidence tells us about their interaction. Throughout this chapter, reference is made to the theoretical framework and aims of this work, concluding with the research questions and structure of this thesis.

1.1 The Male Suicide Crisis

One of the most consistent truths about suicide is that more men die by killing themselves than women (Van Orden, Witte, Cukrowicz, Braithwaite, Selby, & Joiner, 2010). Even when taking a historical lens, Jean-Claude Schmitt suggests that in the Middle Ages, men were three times more likely to end their lives than women (Minois, 1999). In Charles Moore's 1790 suicide treatise, men were described as dying two to one and that there was a link with gambling and alcohol (Goldney, & Schioldann, 2000). In the UK, records of suicide deaths began in 1861 and for every year since, more male deaths have been recorded than female (Seager, 2019). Today, suicide rates vary around the world. In Asian countries, there is more parity between the genders (Kõlves, Kumpula and De Leo, 2013). However, in Europe, around 80% of suicide deaths are male, and in the United States, around 75% (Whitley, 2021). Not only do men die from suicide at higher rates than women, but suicide is a leading cause of death for men in many countries. In the UK, suicide is the biggest killer of men under 50 (Saini, Clements, Gardner, Chopra, Latham, Kumar, & Taylor, 2020). In the USA, suicide was the sixth leading killer of men in 2016 (Centers for Disease Control and Prevention). More male deaths have also been reported in child suicide (Soole, Kõlves & De Leo, 2015).

The male suicide crisis is not only represented by the high number of men who die - which is arguably sufficient to highlight its urgency - it also profoundly impacts significant others.

Between 48 million and 500 million people are bereaved by suicide every year (Pitman, Osborn, King & Erlangsen, 2014) with each death directly affecting an estimated 45 to 80 people (Berman, 2011). Evidence suggests people bereaved by suicide experience increased suicidality and mental health challenges (Oexle, Feigelman & Sheehan, 2020; Pitman et al, 2014). Similarly, for every death by suicide, there are an estimated 20 to 30 people who attempt and 9.2% of people who have thoughts of suicide in their lifetime (O'Connor, & Nock, 2014; Van Orden et al., 2010; Zalsman, Hawton, Wasserman, van Heeringen, Arensman, Sarchiapone, Zohar, 2016). As such, the male suicide crisis includes men who die by suicide, their bereaved loved ones, men who attempt suicide, men living with thoughts and feelings of suicide, and the people who care for men experiencing suicidal despair.

Male suicide represents a significant public health crisis with multiple ripple effects. Understanding why men are at consistently higher risk of suicide is an urgent question that should be central to suicide research (Möller-Leimkühler, 2003) and responded to with suitable funding and interventions (Sher, 2020). However, there has been a profound lack of research into this urgent issue (Bilsker & White, 2011). This thesis aims to address some of the gaps in our understanding by undertaking basic, exploratory research to investigate gendered psychological dimensions of male suicide risk and recovery.

1.2 Suicide

1.2.1 Definition

Suicide is a term which is frequently used in lay circles, but it is complicated to define when placed under scholarly scrutiny (de Leo, Burgis, Bertolote, Kerkhof & Bille-Brahe, 2006). Having a clear working definition of suicide is important because it enables accurate communication across diverse domains - such as research, clinical practice, policy, and public understandings (Silverman, Berman, Sanddal, O'Carroll & Joiner, 2007). Much work has been done to establish a unifying definition of suicide and from their review de Leo et al. (2016) define suicide as:

> “an act with fatal outcome, which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes.”

This definition is useful but too broad for the purposes of this thesis. People who have initiated a behaviour, knowing, or expecting it could end in death could also apply to a political prisoner on hunger strike, a suicide bomber or someone with a terminal illness at an assisted dying clinic. These deaths could be categorised as suicides but are qualitatively different in nature to the behaviour under analysis here, for which an additional caveat is required. Namely, that the suicides we are exploring relate to a desire to end pain that is primarily mental, “using death as the means. The ultimate goal is to stop future consciousness of ongoing suffering” (de Leo et al., 2006, p. 11). In some sense, this thesis is not so much a study of male suicide, but the study of male psychological pain, made manifest in suicidal thoughts and behaviours. What are the drivers of a psychological suffering so intense that it can bring a man to the point when he can no longer bear to exist? How can this pain be reduced to make life more bearable, dignified, purposeful, and worth pursuing?

While suicide is self-initiated, we have to be cautious not to imply that someone "chooses" suicide, freely of their own volition, as if this was a fully desired course of action. In pragmatic terms, there is a degree of accuracy in understanding suicide as self-driven. Ultimately *someone* decides to end *their* lives, and the physical reality of suicide is that it happens within an individual body. However, the factors contributing to "self-initiated suicide" lie beyond the confines of an individual's psychology (Marzetti, Oaten, Chandler and Jordan, 2022). Each of us is in deep, symbiotic interaction with the environmental, political, cultural, and structural worlds around us, which can contribute to our mental pain (East, Dorozenko & Martin, 2021). Similarly, we are each a product of evolutionary processes which as "the mind doesn't leave a fossil record", can never be fully understood in terms of their impact on our psychological states and drivers (p. 177, Garson, 2015). As such, suicide often comes as the consequence of conditions potentially beyond an individual's control and/or understanding - such as job markets, biological temperament, evolved psychological needs, and childhood experiences (de Leo et al., 2006). Suicide is self-initiated in that it may be the only way a person understands - in that moment - their suffering can be adequately resolved. However, the origins of that suffering may exist and/or be compounded by factors external to the individual (de Leo et al., 2006). As such, for this thesis, I wish to take forward

a definition of suicide based on de Leo et al. (2016) definition but which also understands suicide as a behaviour in response to psychological pain and that this pain, while made manifest within an individual, is often in response to external conditions.

1.3 Scientific Study of Suicide

Suicidology - the scientific study of suicide and its prevention - began to emerge from the late 1700s onwards. Previously, throughout history, cultural attitudes and understandings of suicide had varied shaping diverse responses towards people who end their lives or attempt to. In countries like Japan, there is little suggested evidence of negative views towards suicide (Ozawa-de Silva, 2021). Western societies, in contrast, have a long and troubled cultural history. People who died by suicide were denied burial rites, and their corpses sometimes tortured (Minois, 1999). Surviving significant others were punished with estates confiscated and property destroyed (Bähr, 2013; Minois, 1999). In the Middle Ages, people who survived a suicide attempt were tied in wicker cages (Minois, 1999). To contemporary sensibilities, these responses are barbaric. However, they emerged in specific contexts where different understandings and knowledge were available. These cultures often perceived suicide as a moral assault on God's dominion, a murder of a life that belonged to Him, a rupturing of social order and/or symbolic of madness (Bähr, 2013). Suicide needed to be deterred and transgressors punished. It is sobering to reflect that despite threats of eternal damnation - which given the heightened religious beliefs of the time, may have seemed very real - and the suffering surviving loved ones endured, people still died by suicide. It speaks potentially to the depths of psychological pain that underpin suicide that such deterrents were, in many cases, ineffective. As Minois (1999) reflects: "What hold could threats of hell have when people thought life worse than hell?" (p. 154)

The emergence of suicidology gradually shifted suicide from a behaviour under the moral authority of religious and/or legal dominions to a medical context. This reorientation helped to incrementally shift understandings of people who are suicidal from transgressors and/or deviants to people deserving of compassion (Minois, 1999). However, it was only in 1961 that suicide was decriminalised in the UK (Bolster, & Berzengi, 2019). Six years later, in 1967, Shneidman started the first journal dedicated to suicidology (Berman, Silverman, De Leo & Reidenberg, 2021). The placing of suicide in a medical context did not sanitise it of cultural meaning. Instead, suicide became an object of medicine, a behaviour belonging to the

understandings and explanations of psychiatrists and psychologists, many of whom worked to produce “facts” about suicide, resulting in certain scientific methodologies being valued over others (Fitzpatrick et al., 2011; de Catanzaro, 1981) - the implications of which will be discussed later. Suicide become a medical problem, narrowing the framework for understanding suicidal pain to something situated and confined to individual, pathological, and disordered bodies (Marsh, 2020; Marzetti et al., 2022).

1.3.1 Empirical Risk and Recovery Factors

In the last 30 years, over 40,000 research papers on suicide have been written (Soper, 2021). Much of this work has focused on understanding the factors that put people at higher risk of suicide. Non-gender specific risk factors considered to have good empirical support include a connection to suicide either through a past attempt (Barzilay & Apter, 2014; Van Orden et al., 2010) or a family history of suicide (Fazel & Runeson, 2020; O’Connor & Nock, 2014); early life adversity and attachment challenges (Fazel & Runeson, 2020; O’Connor & Nock, 2014; Turecki, Brent, Gunnell, O’Connor, Oquendo, Pirkis & Stanley, 2019; Zortea, Dickson, Gray & O’Connor, 2019; Zortea, Gray & O’Connor, 2021); interpersonal stressors, separation and poor-quality relationships (Kazan, Calear & Batterham, 2016; O’Connor & Nock, 2014); psychiatric disorders and drug and alcohol misuse (Borges, Bagge, Cherpitel, Conner, Orozco & Rossow, 2017; Fazel & Runeson, 2020; Klonsky, May & Saffer, 2016; Turecki et al., 2019). Personality qualities such as anxiety and impulsive–aggressive traits (Turecki et al., 2019) and perfectionism (O’Connor & Nock, 2014), as well as specific emotional states of hopelessness (Beck, Steer, Kovacs & Garrison, 1985) and entrapment (O’Connor & Portzky, 2018) have also been linked to suicide. There has been less research into suicide resiliency factors (O’Connor & Nock, 2014). Previous systematic reviews suggest non-gender specific protective factors include psychological shifts in relation to self, including positive self-regard, self-esteem, self-regulation (Harris et al., 2020; Johnson, Wood, Gooding, Taylor & Tarrier, 2011; Shahram, Smith, Ben-David, Feddersen, Kemp & Plamondon, 2021); and increased social connectedness (Shahram et al., 2021). Psychotherapies such as Cognitive Behavioural Therapy and Dialectical Behaviour Therapy (Turecki et al., 2019), some pharmacological treatments, and policy changes such as lethal means restriction have also been shown to be protective (Zalsman et al., 2016).

Despite the proliferation of research into suicide, recent reviews suggest that the scientific exploration of suicide has brought us no closer to understanding risk or recovery with any utility. Franklin et al.'s (2017) meta-analysis of the predictive power of suicide risk factors found that our ability to predict suicide remains only slightly better than chance after over 50 years of research. Similarly, a recent meta-analysis by Fox et al. (2020), on the effectiveness of suicide prevention interventions, suggests that "across five decades, intervention efficacy has not improved" (p. 1). These are sobering findings. While lives have undoubtedly been saved and supported by commendable work within suicide research, there is a substantial dearth in understanding suicide risk and recovery with significant clarity. Why has scientific progress been so slow? Within the literature, two potential answers emerge: 1) The complexity of suicide as a behaviour which constrains what we can ever know about it. 2) Limitations of the methods used in suicide research and the research questions asked. Situating suicide in a medical context, confined to individual, 'disordered' bodies, may have prevented a holistic understanding of suicidal pain. We will discuss each of these challenges now and their implications for this thesis.

1.3.2 The Complexity of Suicide

What can we know conclusively about suicide? We know that death is the consequence. A biological being no longer draws breath. As far as we know, a conscious mind no longer thinks or feels. Beyond this, establishing unifying "facts" about people who die by suicide is challenging. Studying human behaviour is often messy and imprecise. The human brain "is one of the most complex systems on Earth" (p. 2, Lisman, 2015). We still do not fully understand how the brain works, how consciousness is produced, and how brains, bodies and environments interact to generate certain behaviours. Additionally, psychological pain manifests in biological bodies and brains that have evolved over millions of years in ways we do not understand (de Catanzao, 1981). Within this context of incomplete knowledge, studying perhaps the most complex human behaviour of all - suicide - creates additional limitations for what the scientific pursuit of knowledge can meaningfully achieve.

The decision to die by suicide is potentially the most significant of all human behaviours, given its consequences. Ending your life requires overriding perhaps our most primary of instincts - to survive. Survival appears to be an instinct fundamental to all life forms (Lengvenyte, Conejero, Courtet, & Olié, 2019). If life flourishes best when species are

oriented towards preserving it, it seems logical to assume that negating such a deep-seated impulse and enacting a decision of unparalleled magnitude - in terms of outcomes for the organism doing the behaviour - must come as a consequence of a vast interaction of factors.

Evidence has shown that suicidal behaviour is situated within an extensive terrain of potentially relevant phenomena. A person's suicide risk holds genetic, psychological, clinical, environmental, cultural, sociological, and evolutionary dimensions (Leenaars, 1996; Turecki et al., 2019). As such, for each suicide there is often a complex web of relevant risk factors that converge on a person's decision to end their life - from the micro epigenetic level, such as changes to DNA methylation and histone modifications in response to early life adversity (Turecki et al., 2019), to the macro-scale and structural factors such as education opportunities, recessions, and wars (de Leo, 2002; Pirkis, Macdonald & England, 2016). Given this expansive and extensive spectrum of risk, while science can help establish insights into suicidal behaviour, these insights cannot explain every instance of suicide. There are too many complex factors at play, which are constantly shifting. The story of every suicidal crisis is unique because it is the story of a human life, and every life is unique in its circumstances and the biology of the being living it.

Bryan (2022) suggests that suicide fits the category of what Rittel and Webber (1973) describe as a "wicked problem" - a highly complex issue that involves multiple factors in constant flux. Interventions for wicked problems may mitigate aspects of the problem but will rarely be able to resolve it in its entirety. The profoundly tragic nature of suicide means work to understand it better is urgent, but this work must be situated within an acceptance of the complex terrain in which it manifests, and any findings, including those in this thesis, should be held with fragility and humility with regards their validity and generalisability.

Suicide research is constantly evolving with new findings expanding upon previously established risk factors (Franklin et al., 2017). It is commonly cited that between 90%-95% of people who die by suicide have a mental health diagnosis (Bertolote & Fleischmann, 2002; Cavanagh, Carson, Sharpe, & Lawrie, 2003; Van Orden et al., 2010). However, analysis of people who die by suicide using a firearm—predominately men – suggests that they are less likely to have a long-term mental health diagnosis (Kaplan, McFarland & Huguet, 2009). Of course, we do not know the reality of these people's mental health. For example, they may never have accessed medical support and have been living with an undiagnosed condition.

The point is that a mental health diagnosis cannot necessarily be relied upon as a robust indicator of suicide risk, indeed, the vast majority of people with a mental health diagnosis will not die by suicide. Impulsivity was once thought to be a reliable risk factor, but its effect is probably weaker than originally thought (O'Connor & Nock, 2014). Past suicidal behaviour is considered an established risk factor, but men are more likely to die on a first attempt (Jordan & McNiel, 2020). These challenges demonstrate the difficulty of establishing generalisability about suicidal behaviour. Despite the proliferation of suicide risk factors, we have no reliable predictors of who is most at risk (Danchin, MacLeod & Tata, 2010; Franklin et al., 2017).

The lack of concrete findings in suicidology speaks to the complexity of researching suicide which is further complicated by the absence of the phenomenon under investigation. People who die by suicide may be psychologically distinct from those who attempt suicide or experience suicidal ideation. A body of research exploring gendered differences in suicide notes has sought to elicit insights from these final communications. Leenaars' (1988) study of predominately US suicide notes, reported no known sex differences. Lester's (2008) study of gender differences in 40 suicide notes from Germany found that men were more concerned with mentioning others than on causation and that men wrote longer notes and used fewer unique words, "fewer insight words (such as think, know consider) (…) fewer tentative words (such as maybe, perhaps) (…) and more words concerned with down (such as down, below, under)" (p. 798). Canetto and Lester's (2002) study of 56 US suicide notes found that in male and female notes, romantic issues were mentioned more frequently than problems related to school or work. While suicide notes can provide insight into the final moments of a person's unendurable despair, their contents often lack contextualisation and can be challenging to interpret (Leenaars, 1988). Suicide notes can vary from one word to multiple pages, and only between 3-42% of people who die by suicide leave a note (Paraschakis, Michopoulos, Douzenis, Christodoulou, Koutsaftis & Lykouras, 2012). Some researchers caution that conclusions drawn from notes only will contain biases and cannot be generalised to all deaths by suicide (Leenaars, 1998; O'Connor, Sheehy & O'Connor, 1999). This is true not just for suicide notes, but all aspects of suicide research. In short, while suicide notes can offer useful insights into the final information a person may want to communicate, their contents must be interpreted with caution and contextualised within a larger understanding of suicide, and they do not tell us too much about male risk specifically.

1.3.3 Methodological Limitations of Suicidology

The lack of meaningful progress in suicide research brings into question whether current methodological approaches serve us effectively. In the pursuit of identifying generalisable risk factors, quantitative (Scourfield, 2005) and epidemiological (Richardson, Robb & O'Connor 2021) studies have dominated suicide research. Qualitative work is comparatively rarer (Canetto & Cleary, 2012). From 2005 to 2007, for example, less than 3% of research in the three leading suicidology publications was qualitative (Hjelmeland & Knizek, 2010).

The privileging of quantitative work has led to various problems concerning the utility of the current evidence base. Criticisms include: 1) risk factors identified by existing literature such as early-life adversity or unemployment are relatively common. Millions of people experience unemployment but do not kill themselves. Similarly, these risk factors are also indicators of other mental health conditions such as depression. As such, they offer limited utility in identifying people specifically at risk of suicide (Crocker, Clare & Evans, 2006; Franklin et al., 2017); 2) established suicide risk factors may be distal and predict thoughts of suicide which are more common in the population and not predictive of suicide attempts which are rarer and potentially psychologically distinct (Glenn, Cha, Kleiman & Nock, 2017). As such, we don't have an in-depth understanding of the different psychological profiles between men who think about suicide and men who attempt suicide; 3) research has often focused on understanding risk factors in isolation, consequently the field has established numerous singular risk factors rather than looking at how risk factors interact. This information can feel challenging to make use of. Suicide is a multi-faceted behaviour. Singular risk indicators, decontextualised from the complex psychological and lived realities in which they manifest, have limited utility in what they can meaningfully tell us about people at risk. As already mentioned, millions of people are unemployed but do not kill themselves. What is it about unemployment in specific people that can lead to suicide? What else is happening psychologically to cause that outcome? Researchers have called for a more robust understanding of risk factors in dynamic interaction (Franklin et al., 2017; Van Orden et al., 2010) and more investigations into the psychological pathways that may underpin these risk factors and lead to suicide (Bilsker & White, 2011); 4) suicidal states are temporal - ideation and attempts can emerge quickly and we need more real-time data collection to understand how proximal risk evolves (O'Connor & Kirtley, 2018; Rudd, 2006); and, 5) suicide research has often taken as its unit of study the mental health of the suicidal

individual. This approach can fail to problematise how other factors, such as social, cultural, political, evolutionary, and economic conditions, may contribute to suicide risk (White, 2015). All these factors and more have impacted our ability to predict suicide and develop effective interventions (Glenn et al., 2017).

How do the current challenges in suicide research inform the approach in this thesis? As described, some issues - such as the absence of people who have died by suicide from research - cannot be resolved, and this work is set within those limitations. However, other challenges are amenable to a change in approach. As such, this thesis aims to specifically advance our understanding of the psychological pathways underpinning male suicide risk and recovery. This includes exploring psychological risk factors in interaction, possible distinctions between distal and proximal risk, potential psychological differences between men with thoughts of suicide and men who have attempted suicide, and the potential influence of external factors, such as sociocultural conditions, on men's psychological pain.

1.4 Suicide and Human Psychology

Suicide appears to be a uniquely human behaviour, with no robust reports of self-initiated deaths in other species (de Catanzao, 1981; Soper, 2018). This suggests that a certain degree of human-unique psychology may be required to enact suicide and that this psychology develops at a certain age, given the scarcity of reported suicide in children under eight (Soole, Kõlves & De Leo, 2015). The high rates of male suicide deaths suggest there may be specific factors related to male psychology that create additional vulnerability in men. Understanding the psychological drivers of suicidal pain in men is vital for identifying men at risk and building effective interventions.

1.4.1 The First Suicide Note

We do not know when the first suicide happened, and we never will. Knowing this could tell us so much about the potential alignment of psychological capabilities and environmental conditions that first brought suicide into the repertoire of human behaviours. While suicide potentially predates the written word, for now, early suicide notes are some of our only windows into the development of suicide in the human story. The first potential suicide note we have on record comes from a man living in Ancient Egypt and dates from approximately

4,000 years ago (Ali & El-Mallakh, 2021). Bearing in mind previously noted caveats about the limited utility of suicide notes, this text does, however, offer a moving insight into the potential psychological terrain of one of the first men, on record, believed to be suicidal. The content and themes of the note present a man seemingly consumed by psychological pain, a pain that appears to relate in part to an overwhelming sense of inhabiting a contaminated and ruined self-hood:

> "Look, my name is reeking:
> look, more than carrion's smell
> on Harvest days, when the sky is hot." (p. 5, Ali & El-Mallakh, 2021)

He also appears to be enduring profound isolation, as he laments changing social and cultural conditions that appear to have caused a rupture in connection and intimacy:

> "To whom can I speak today?
> Faces are obliterated,
> every man with face down to his brothers.
> To whom can I speak today?
> Hearts have become greedy.
> there is no man's heart one can depend on." (p. 6, Ali & El-Mallakh, 2021)

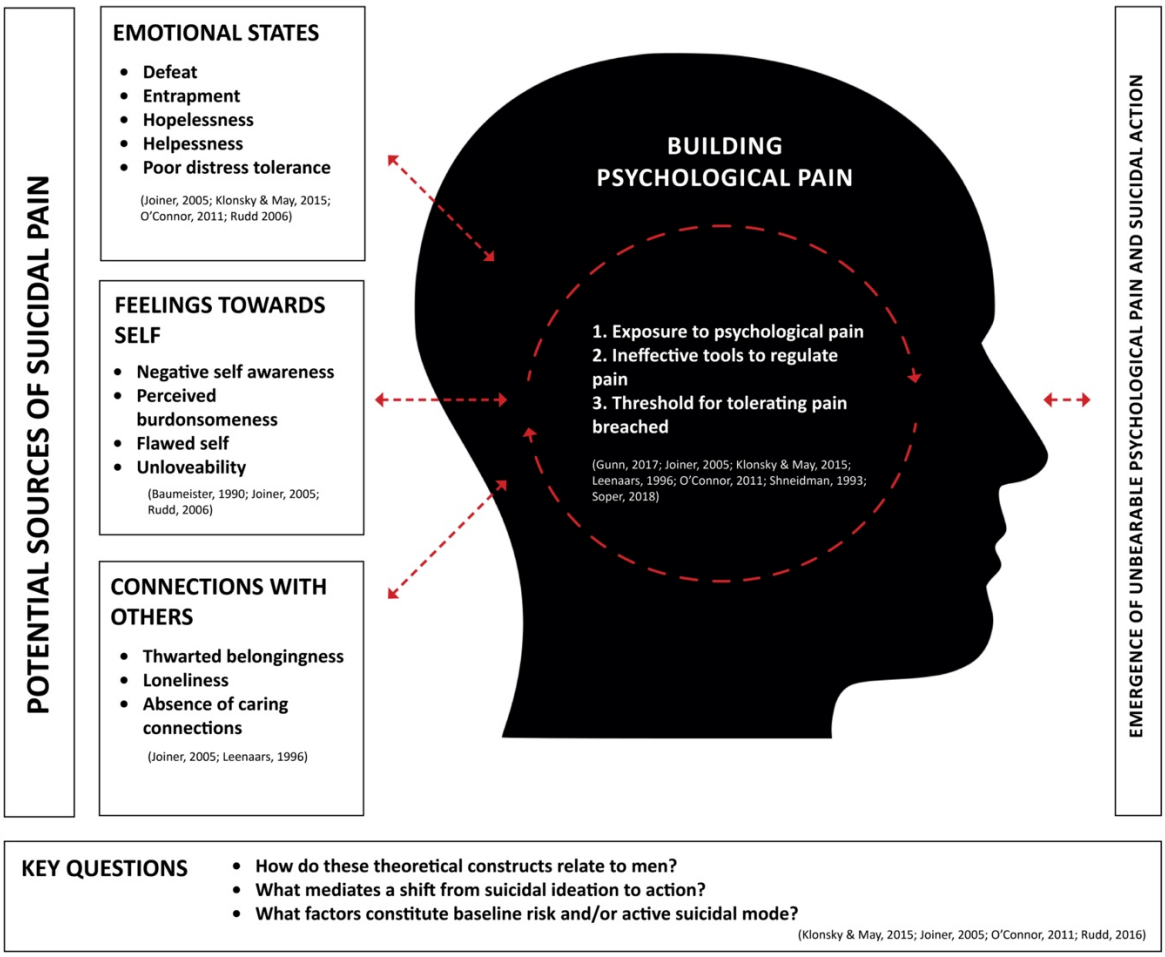
These themes of a ruined self and despairing isolation seemingly echo from a life lived 4,000 years ago to within the suicide theories of the modern era. This suggests, perhaps, that the core mechanics of suicide - the tectonic plates of evolved psychological needs on top of which all sorts of permutations of culture and societies may be built - are as similar today as they were four millennia ago.

1.5 Psychological Theories of Suicide

In recent years, various theories have been operationalised to explain suicidal behaviours from a psychological perspective (O'Connor & Nock, 2014). Given the complexity of suicide, researchers recognise that it would be difficult for one theory to explain all suicidal incidences and different theories emphasise the role of different psychological phenomena

(Gunn, 2017; Leenaars, 1996). The subsequent sections provide a summary of the major theories and the phenomena they conceptualise as key - see also Figure 1.1.

Figure 1.1: *Key phenomena from psychological theories of suicide*



1.5.1 Psychological Pain and Suicide

Shneidman (1993; 1998) described suicide as the drive to escape intolerable psychological pain. For Shneidman, this pain stems from unmet psychological needs and suicidal behaviours are activated when that pain is experienced as reaching unbearable levels. In this theoretical context, understanding suicidal behaviours is about: 1) understanding an individual's exposure to psychological pain; 2) their tools to regulate pain; and 3) their threshold for when pain has become intolerable. Suicide prevention is conceptualised as supporting individuals to meet their thwarted psychological needs and to learn to regulate their psychological pain. For Shneidman, suicide is not a mental illness but "a

phenomenological event" (1993, p. 146). People who die by suicide are psychologically distressed but not necessarily clinically ill.

1.5.2 Psychological Pain, Suicide and Connections with Others

Leenaars (1996) builds on Shneidman's ideas to include the interpersonal domain more robustly. Humans are social beings, and the propensity to accrue psychological pain is woven into the fragility and complexity of our interpersonal dynamics. Leenaars describes suicide as an "intrapsychic drama on an interpersonal stage" (p.224). Leenaars 'Multidimensional Malaise' conceptualises suicide as an interaction between intrapsychic factors (psychological pain, inability to cope) and interpersonal issues (problems establishing and managing relationships, relationship losses). Like Shneidman, Leenaars contends that suicide is not just about psychological pain but about a person's ability to cope with that pain. Suicide is not caused by a singular event. Each suicide carries a personal life history, relating in part to the pain an individual has accrued over their life and how their tools to regulate that pain have been affected.

1.5.3 Psychological Pain, Suicide and Feelings Towards Self

Baumeister's (1990) 'Escape from Self' theory focuses on psychological pain relating to thoughts and feelings towards self. He proposed the following six steps to a suicidal crisis that he conceptualised as driven by aversive self-awareness: 1. a person experiences an awareness that their life conditions are not as expected; 2. blame for this is attributed to the self, which; 3. generates a negative evaluation of self; and 4. negative feelings towards the self. 5. The person tries to escape awareness of this aversive sense of self through processes of cognitive deconstruction that seek to shut down and limit cognitive awareness by focusing on less meaningful and cohesive forms of thought. To maintain this state, individuals can become passive to long-term goals. In a struggle to avoid meaning, these processes can lead to emotional emptiness and further negative affect. 6. A deconstructed mental state can lower inhibitions and increase the possibility of suicide as long-term consequences of death are not fully comprehended. For Baumeister, recovery was partly about developing new interpretations of life events and new compassionate understandings of self.

1.5.4 Evolutionary Theories of Suicide and Psychological Pain

Gunn's (2017) 'Social Pain Model' places the concept of psychological pain in an evolutionary context. Pain evolved as an essential survival mechanism that captures an organism's attention and drives action to mitigate pain (Finlay & Syal, 2014; Gunn, 2017; Soper, 2018). Without effective and sensitive pain systems, humans would be vulnerable to danger in ways that would compromise our survival. A body of evidence now suggests that some of the neural pathways activated during experiences of physical pain are also activated during incidents involving social pain (Eisenberger & Lieberman, 2004). Gunn hypothesises that given the centrality of sociality to human life; social pain may have co-opted physical pain systems to keep an organism focused on ensuring their social safety. This may leave humans vulnerable to accruing high levels of social pain. As such, suicide may be "a by-product of the evolutionary adaptation of pain" (p.283).

Soper (2018) further expands these ideas in his 'Pain-and-Brain' theory. He claims that suicide is the detrimental by-product of not just the evolution of pain but also the evolution of the mature human brain, which, unlike other animals, has the cognitive capacity to conceive and enact suicide to escape that pain.

1.5.5 Ideation to Action Models

Joiner's 'Interpersonal Theory of Suicidal Behaviour' (2005; 2010) was the first of three key models of suicide developed to help differentiate between factors related to suicidal ideation from factors that lead to the rarer behaviour of making an attempt, or dying by suicide (Klonsky, May, & Saffer, 2016). Joiner's theory is built around three key constructs that comprise two dimensions each; 1) 'thwarted belongingness', comprised of loneliness and the absence of mutually caring connections; 2) 'perceived burdensomeness', comprised of the belief that a flawed self is a burden to others and aversive self-hatred; and 3) 'increased capability for suicidal action', constituted by increased tolerance to pain and a diminished fear of death owing to exposure to distressing experiences such as childhood adversity, trauma, and violence. Joiner describes the suicide causal pathway as such: thwarted belongingness and perceived burdensomeness are sufficient causes for the emergence of thoughts of suicide; when these states are perceived as unchangeable, hopelessness causes an

active suicidal desire; suicide plans and attempts emerge when a person also has acquired capability in terms of fearlessness about death and pain.

More recently, O'Connor proposed the 'Integrated Motivational-Volitional Model' (O'Connor, 2011; O'Connor & Kirtley, 2018), a tripartite model of suicidal behaviour. In the 'pre-motivation phase' background factors such as childhood adversity and biological/genetic vulnerabilities increase suicide risk through their impact on the other model parts or phases. The 'motivation phase', describes the psychological processes that lead to suicidal ideation. Here, proximal feelings of defeat and humiliation contribute to a sense of hopelessness, entrapment and thoughts of suicide. The 'Volitional Phase' describes the factors that lead to suicidal action. Like Joiner's model these include increased capability, but O'Connor acknowledges other contributors such as past exposure to suicidal behaviours (self or others) and impulsivity. In Joiner's model belongingness and burdensomeness are psychologically critical, for O'Connor it is feelings of defeat and entrapment (O'Connor & Nock, 2014).

In Klonsky and May's 'Three-step Theory' (2015) it is the interaction of pain, hopelessness, connections, and suicide capability that mediate ideation-to-action. Thoughts of suicide develop due to the interaction of pain (usually psychological) and hopelessness. Unlike Joiner who conceptualises thwarted belongingness as a critical risk component, Klonsky and May state that suicidal ideation can develop without disrupted connections and therefore connections should not be operationalised from a risk perspective. Instead, they conceive connections as a protective factor in that they can buffer a person from suicidal action. They also broaden connections beyond interpersonal dynamics to include "any sense of perceived purpose or meaning that keeps one invested in living" such as a job or religion (p. 117). Like Joiner, they believe that acquired capabilities guide the transition to suicide attempts.

1.5.6 Fluid Vulnerability

One last significant psychological theoretical contribution is Rudd's (2006) 'Fluid Vulnerability Theory' (FVT), which seeks to help clinicians assess imminent suicide risk. The FVT conceives that everyone carries an individual 'baseline risk' for suicide and an individual threshold for when a 'suicidal mode' will be activated. The suicidal mode represents acute risk and imminent danger to life. The suicidal mode has cognitive, affective, physiological, and motivational components and is underpinned by four core beliefs:

“unlovability, helplessness, poor distress tolerance, and burdensomeness” (Rudd, 2006, p. 356). Critically the FVT explains that, as the body cannot sustain heightened arousal states, the suicidal mode is necessarily temporal and suicide risk will naturally ebb and flow. People may experience recurrent suicidal crises, but each one is a discrete, time-limited episode. The FVT can help clinicians differentiate between enduring risk factors that contribute to baseline risk and warning signs indicating that the suicidal mode is active and a threat to life is more imminent. Different interventions are required to; 1) deactivate a person’s suicidal mode; and 2) resolve their underlying baseline risk.

1.5.7 Social and Cultural Contexts

Psychological theories often fail to account for how our social and cultural worlds can impact our psychology and contribute to suicidal despair. Durkheim’s (1897) seminal sociological study of suicide provides an important theoretical bridge between the psychology of the suicidal individual and their social environment. His ideas explore how different social contexts can facilitate specific variants of despair (Engelbrecht, 1970). Durkheim classifies suicide into four types based on social integration and moral regulation (Durkheim, 1897; Mueller et al., 2021).

Egoistic suicide is rooted in low social integration and concerns people whose despair may come from feeling detached from society and a lack meaningful connections. In contrast, altruistic suicide relates to people who are excessively socially integrated. Their strong ties to the collective may lead them to sacrifice their lives for the benefit of the group.

Durkheim describes anomic suicides as occurring during periods of social upheaval and unrest when the norms that regulate collective living may break down. The resulting loss of structure and meaning may leave individuals adrift. People may despair because of a loss of purpose, hope, and direction for their lives. Fatalistic suicide, in contrast, describes suicides where societies are excessively morally and socially integrated. Certain individuals may feel oppressed by excessive social constraints and be driven to suicide.

Durkheim’s ideas highlight the role cultures and societies play in shaping and directing our behaviours and, subsequently, our psychological pain and despair. Given that cultures have specific rules governing male and female behaviour, they also have the potential to shape different genders' psychological pain in specific ways.

1.5.8 Summary

In summary - see also Figure 1.1 - psychological domains identified as significant across different suicide theories include psychological pain and tools to regulate it (Gunn, 2017; Leenaars, 1996; Shneidman, 1993; Soper, 2018), perceptions, understandings, and feelings towards self (Baumeister, 1990; Joiner, 2005; Rudd, 2006; Soper, 2018), interpersonal connections and belongingness (Klonsky & May, 2015; Joiner, 2005; Leenaars, 1996), feelings of hopelessness (Klonsky & May, 2015; Joiner, 2005; O'Connor, 2011), helplessness (Rudd, 2006); defeat and entrapment (O'Connor, 2011). Additionally, factors that mediate suicide ideation and suicide action (Klonsky & May, 2015; Joiner, 2005; O'Connor, 2011) and factors that contribute to baseline risk versus active suicidal mode have been identified as theoretically significant (Rudd, 2006).

Franklin et al. (2017) note, that given the range of psychological factors identified as theoretically important, either some of these theories are fully/partially inaccurate and/or apply to specific populations only, and to progress the field, we must "winnow the accurate theories or accurate theory elements from the less accurate theories" (p. 1). Within these psychological theoretical frameworks, there is a critical need to understand if and/or how they can help explain the higher prevalence of male deaths by suicide, and the potential role of cultural contexts concerning increased male suicide risk.

1.6 Male Suicide

As previously mentioned, it is difficult to establish “truths” about suicide, however, one seemingly consistent reality is that more men die than women and there has been a lack of research into why. To the authors’ knowledge, there has only been one quantitative systematic review of male-specific suicide risk which identified 68 different risk factors (Richardson et al., 2021). Risk factors with the most compelling evidence were: 1) substance use and dependency (alcohol and/or drugs); 2) relationship status (being unmarried, single, divorced, or widowed); and 3) a diagnosis of depression (Richardson et al., 2021). Other suicide risk factors commonly associated with men include unemployment and low income (Mallon, Galway, Rondon-Sulbaran, Hughes & Leavey, 2019; Qin, Agerbo & Mortensen, 2003); substance misuse and intoxication during attempt (Miranda-Mendizabal et al., 2019;

Sher, 2020; Sørensen, Thorgaard & Østergaard, 2020; Swami, Stanistreet & Payne, 2008); and the use of lethal means (Möller-Leimkühler, 2003; Sher, 2020; Swami et al., 2008) - in America nearly 92% of firearm suicides were male (Kaplan et al., 2009). Critically, it is also reported that men are more likely to die on a first attempt without a mental health diagnosis and without being in contact with mental health services (Jordan & McNiel, 2020; Tang et al., 2022). A recent scoping review of male suicide prevention interventions identified various potential protective factors including multimodal interventions, community support, training for mental health professionals, service delivery in informal settings, cognitive therapies, and support for men to build emotional regulation skills and social connection (Struszczyk, Galdas & Tiffin, 2019). Marriage has also been identified as a male-specific protective factor (Duarte, El-Hagrassy, Couto, Gurgel, Fregni & Correa, 2020).

1.6.1 The Gender Paradox

Scholars have described a gender paradox whereby more men die by suicide, but more women attempt, this paradox is not well understood (Canetto & Sakinofsky, 1998). Explanations for why men die at higher rates include experiences over their life course that expose men to injury, i.e., through physical jobs, contact sports, and risk-taking behaviours. These experiences may de-sensitise men to pain, increasing their pain tolerance and capability for suicidal action (Van Orden et al., 2010). Men's preference for lethal means, such as firearms, has also been suggested as a distinguishing factor (Coleman, Kaplan, & Casey, 2011). Men and women may experience similar levels of psychological distress, but a male preference for lethal means and potential reluctance to seek help, may mean more men die when they attempt suicide, whereas more women survive. Women are potentially more likely to recognise distress within themselves and employ flexible coping strategies including seeking professional help or drawing on interpersonal support (Stack, 2000).

1.6.2 The Gender Elephant

Gender is the elephant in the room of suicide research. Even though suicide statistics consistently indicate that more men die by suicide than women, the role of gender has rarely been problematised by suicidologist's (Samaritans, 2012; Seager, 2019; Swami et al., 2008). Few researchers have asked, what is it about male psychology that may elevate male suicide risk? Instead, gender is often "treated as a static demographic variable" rather than "a

culturally mediated social construction" (p. 529, Bilsker & White, 2011). This omission seems strange given that, as Seager says:

> male gender is almost universally the biggest single risk factor for suicide since records began, it logically follows that suicide research if nothing else would be dominated by studies of male psychology and behaviour. In fact, the opposite is the case. (Seager, 2019)

As such, there is a profound void in our understanding of how male psychology may impact male suicide risk and recovery (Bolster, & Berzengi, 2019). This thesis seeks to address some of these gaps, and I will now clarify what dimensions of male psychology will be taken as the focus of this study.

1.7 Male Psychology

Psychology is the study of mind and behaviour (APA Dictionary, psychology entry, 2023). Our psychology exists in biological bodies, shaped by evolutionary forces and wired to different cultural realities. As such, male psychology has biological (sex) and cultural (gender) components, both of which have an evolutionary history. Here I will briefly describe each dimension to clarify the parameters of this work.

1.7.1 Male Sex

Sex is a complex biological reality that is determined in different ways in different species. In alligators, the temperature that eggs are incubated at decides sex, certain fish can change sex during their lifetimes, and for mammals, such as humans, biological sex is genetically determined (Levay, 1993). Humans appear to have evolved from unicellular creatures who mated by fusing and combining the same genetic material (Levay, 1994). At some point in our evolutionary history - some suggest potentially 1 billion years ago - two separate gametes evolved, one female owing to its bigger size and one smaller male (Lehtonen & Parker, 2014). Each gamete came to carry its own genetic material. Thus when female and male gametes combined, instead of fusing the same genetic material, they combined different genes, introducing more genetic diversity into our evolutionary lineage. Diverse genetic combinations helped remove dangerous mutations and allowed new variations and

adaptations to emerge, improving survival chances in shifting ecological contexts (Coyne, 2010). From one perspective, humans are biologically a two-sex species as reproduction requires the combination of a female and male gamete. However, this does not mean that sex is defined on a singular gamete-type dimension. Instead, researchers today understand biological sex to be multi-dimensional and "the result of a choreography of genes, hormones, gonads, genitals, and secondary sex characters" (p. 8, Richardson, 2013).

1.7.2 Male Sex and Male Psychology

Over millions of years, the different morphology of the gametes and mating strategies necessitated by them brought forth potential changes in the behaviour of organisms sexed as male and those sexed as female (Richardson, 2013). Male gametes are multiple, smaller, and evolutionary "cheaper" for an organism to invest. Female gametes are fewer, larger, and mating decisions are therefore more "costly" and, consequently, considered. This set in motion evolutionary-specific behavioural changes in the two sexes that have shaped psychologies in ways we cannot fully comprehend (Garson, 2015). The males of our nearest living ancestors - chimpanzees and bonobos - display very different behaviours. In chimpanzees, males seem to dominate females and societies are often more aggressive, whereas there appears to be more gender parity and peace in bonobo societies which often seem matriarchal (Surbeck, Deschner, Schubert, Weltring & Hohmann, 2012).

Historically, in humans, a person's sex was understood to cause essential differences in behaviour and psychology (Rippon, 2019). These assumptions led to different cultural oppressions of men and women. Men were frequently sent to war (Gendler, 2020). Women often could not access education or employment (Rippon, 2019). While theories of gender have shifted our understandings away from an essentialist view of sexed behaviour, there may be deeply embedded evolutionary drives that could account for aspects of men's increased suicide risk. For example, some scholars suggest that over our evolutionary history, men have been required to take more risks and be more aggressive (Perry, 2014). A higher evolutionary propensity for these behaviours could influence male psychology and male suicide risk. Humans are not at the mercy of our evolutionary drives, we have also evolved complex cognitive decision-making capabilities. However, it is important to acknowledge that deep and unknowable evolutionary forces may impact men's psychology and suicide risk. At times, I will try to contextualise potential findings in research from the evolutionary

psychology literature. As Soper (2021) asserts, to understand suicide, we also have to consider how processes of evolution may have shaped biological beings with particular psychological needs. However, the primary focus of this thesis is to explore dimensions of male psychology relating to gender.

1.7.3 Male Gender

The scholarly separation of sex and gender helped dismantle essentialist views of female and male behaviour. The first academic writing on gender is believed to be Money (1955), who distinguished sex as biological and gender as "all those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman, respectively" (p. 254). Most scholars now distinguish between "sex" as referencing the biological, physiological, and anatomical characteristics a person is born with, which broadly fall into categories of male and female with some variety (Richardson, 2013; Sussman, 2012). By contrast, "gender" refers to the cultural ideas we inherit about how men and women should behave. These distinctions broadly imply "that while sex may be fixed and given, gender is fluid and changeable" (p.8, Richardson, 2013).

While researchers now consider sex (biology) and gender (culture) to reference different phenomena, in reality, they cannot be neatly separated and independently studied. Sex and gender are intertwined, like the hydrogen and oxygen atoms that make up water. Culture happens to biological beings, and biological beings do culture (Ashfeld & Gouws, 2019; Hjelmeland & Knizek, 2016; Richardson, 2013; Seager, 2019). We cannot ethically do experiments to control for the influence of culture and understand biology's specific impact on male behaviour (Sussman, 2012). Consequently, self-reliance in men may increase suicide risk, but we cannot account for how much men are self-reliant as an innate biological impulse versus the influence of cultural norms for men to be so.

Levant and Pryor (2020) note the need to distinguish between an understanding of masculinity as "synonymous with being biologically male" and masculinity as "a set of thoughts, feelings, beliefs, and behaviors" external to male biology (p. 15). As such, in this thesis, we are asking how cultural ideas of gender – separate to male biology - impact male psychology and male suicide risk. However, this is not to claim that gender can be studied in isolation from sex, nor to diminish the potential for male sex to interact with male psychology and suicide risk. For example, research suggests a possible relationship between suicide and

low testosterone in older men and high testosterone in adolescent males, mediated by changes in mood, aggression, and/or depression (Sher, 2017). Male sex differences and their impact on male psychology are important areas of research but outside the scope of this thesis.Si

1.7.4 Male Gender and Male Psychology

This thesis will focus on the potential impact of gender on male psychology and suicide risk. As mentioned, gender refers to cultural ideas of masculinity, not biological characteristics. Defining culture is a subject of much debate, with many different approaches operationalised in research (Colucci, 2013). Sapolsky (2017) describes culture as "how we do and think about things, transmitted by nongenetic means" (p. 279). For the purposes of this thesis, this definition provides a solid working framework. Humans worldwide and throughout history have faced a similar challenge of how to live well together. Our capacity to create culture is the tool we have used to answer that challenge. Cultures are the rulebooks we create for how to live together that guide behaviour and sense-making.

Every human exists in a cultural context, from isolated communities in the Amazon rainforest to the inner-cities of Dhaka, Bangladesh, to the rural farms of West Scotland. Each culture has its own history, values, beliefs, moral practises, and standards of behaviour which influence how people feel about themselves and others, their social value, their past and their future, and what they should strive for. Humans are one species, but the cultural variation in how we construct our societies, relationships, and sense of self is spectacularly diverse. Manifestations of culture have a biological constraint - there are no societies where humans can independently fly or become invisible. Therefore, all human societies are bound by the physical limitations of our biology. However, the expanse of the human imagination means all sorts of cultural permeations have arisen.

We inherit cultures from the generations that lived before us, and, as such, we are often born into societies with rich and long cultural traditions (Triandis, 2007). Cultures can manifest externally in objects such as institutions, clothing, sports, arts, and language, and cultures can operate internally in shaping people's psychology, worldviews, meaning systems, and cognitive/emotional schemas (Colucci, 2013; Heine, 2007). As such, culture can permeate human behaviour, including the meanings and understandings shared by people (Heine, 2007; Hjelmeland, 2013; Laubschler, 2003). For example, what does it mean to be a man? What

emotions are socially acceptable in men? What constitutes a man of social value? What makes a man's life meaningful? Answers to these questions are embedded in cultural norms and meaning systems and potentially play a critical role in contributing to the psychological pain and suicidal distress men may endure depending on whether they feel they meet these standards or not (Colucci, 2013). Despite the pervasive power of culture, understanding its impact on suicidal behaviours has not been a central part of suicide research (Hjelmeland, 2013).

In the majority of societies today, and throughout history, there are people who identify as men and as women. As such, ideas of gender have played a significant role in how cultures orientate themselves. Expectations for how men and women should behave are often described as a 'script' that people are socialised in and internalise (Möller-Leimkühler, 2003). Cultures vary and men in different cultural settings will be exposed to different scripts with regard to socially valued male behaviour. Men will absorb, embody, and reject these ideas differently at different times; therefore masculine behaviour and identities cannot be considered uniform, static, or homogenous (Coston, & Kimmel, 2012; Struszczyk et al., 2019; Sussman, 2012). The study of men and masculinity became an academic field in the late 1980s, formalised via conferences and journals on the topic (Connell, & Messerschmidt, 2005). Connell's theory of hegemonic masculinity is perhaps the most significant contribution to the field. Connell (1987) describes that while cultures do not offer one singular script about masculinity, each culture often reveres a specific expression of masculinity which becomes hegemonic by dominating expectations and ideals about the characteristics that define men at their most socially valuable. Few men will embody all aspects of hegemonic masculinity. Instead, hegemonic masculinity asserts its social power and currency by uplifting an idealised version of masculinity that men are measured against.

The characteristics that have dominated quantitative explorations of masculinity and are considered hegemonic - at least in Western contexts - include avoiding the feminine, concealing emotions, status pursuit, dominance, violence, primacy of work, self-reliance, power over women, and the rejection of homosexuals (Brannon & Juni, 1984; Levant & Fischer, 1998; Mahalik et al., 2003; Oransky & Fisher, 2009; Thompson & Pleck, 1986). Many of these measures were created using western college-age populations and their validity and ability to capture how masculinity is perceived, experienced, and expressed by different demographics of men have been questioned (Thompson & Bennett, 2015).

Researchers have also suggested that we need a new iteration of male norms to reflect shifting social dynamics with hostility to women and sexual minorities less prevalent, in some locations, than in previous times (Thompson & Bennett, 2015).

1.7.5 Male Gender, Male Psychology and Suicide

Many norms of masculinity may enable many men to prosper, especially given that most men are not suicidal (Pirkis, Spittal, Keogh, Mousaferiadisn & Currier, 2017). However, previous research has shown that men who strongly endorse traditional masculine values are at higher suicide risk (Coleman et al., 2011; Coleman, 2015), particularly norms relating to self-reliance (Pirkis et al., 2017). Masculinity can create pressure for men to be in control. Suicidal crises are often indicative of a life spiralling out of control and suicide has been suggested by some scholars as a masculinised means of regaining authority and agency (Keohane & Richardson, 2018; Samaritans, 2012). Male norms for control and competency, and emotional suppression may reduce the options available for men when in psychological distress, potentially increasing the cognitive availability of suicide. It is also suggested that attempting suicide and surviving can be considered a more feminine behaviour (Scourfield, 2005). However, this may also mean women who die by suicide are underreported because it is less expected or accepted (Schrijvers, Bollen, & Sabbe, 2012). Given the higher rates of suicide in men and the lack of research exploring the role of male gender in suicide, we urgently need to understand how and why cultural ideas of masculinity may impact the psychology of men who are suicidal and not men in general.

Suicidal pain is a shared human experience. Although men have higher suicide death rates, individuals of all genders experience psychological distress that may lead to thoughts of suicide, attempts, and deaths. Nonetheless, this thesis does not aim to be a comparative study between men and other genders. While such research is another valuable way of understanding psychological differences between genders concerning suicidal pain, our focus here is to address the dearth of research into male suicide specifically. We aim to build up a rich and robust insight into the psychology of men who are suicidal. We hope our findings can create a foundation of understanding into male suicide that future comparative studies could build upon.

1.8 Thesis Aims and Structure

Suicide research has been in earnest production over the last 50 years. However, there are still significant gaps in our knowledge, especially concerning the biggest risk population - men. Despite male suicide rates being consistently higher than women, there has only been a modest amount of research focused on male suicide specifically, and very little of that work has focused on understanding the relationship between male gender, male psychology, and suicide. This thesis aims to further our understanding of how gendered aspects of male psychology may interact with male suicide risk and recovery. Given the paucity of existing research, this thesis does not start with any hypothesis about male suicide to be tested and verified. Instead, this thesis seeks to produce new knowledge, ideas and hypotheses, and define the key relevant phenomena (Swedberg, 2020). As such, this thesis aimed to conduct mixed-methods research to advance our understanding of the following research questions:

1. What is the potential relationship between male gender, male psychology, and male suicide risk and recovery?
2. What are the psychological pathways underpinning male suicide risk and recovery factors, including:
    a) What are the potential psychological distinctions between proximal/distal risk in men?
    b) What are the potential psychological distinctions between men with thoughts of suicide and men who have attempted suicide?
3. What are the barriers men who are suicidal experience in seeking professional support?
4. What are the key research priorities to help advance our understanding of male suicide risk and recovery?

This thesis has seven chapters, including this introduction (Chapter 1). Chapter 2 provides a brief description of the methodological and ethical considerations for the empirical studies of the thesis. Chapter 3 is a qualitative meta-synthesis of the male suicide literature. It develops two models: 1) ‘3 ‘D’ Model of Masculinity Norms and Male Suicide Risk’ (3 ‘D’ Risk) and 2) ‘3 'R' Model of Male Suicide Recovery’ (3 ‘R’ Recovery). These models explore potential psychological pathways underpinning male suicide risk and recovery, including distinctions between proximal/distal risk. Chapter 4 is a cross-sectional study developed to explore

psychological phenomena from the 3 ‘D’ model and how they may distinguish men who are not suicidal, from men who have had lifetime thoughts of suicide, and men who have made a suicide attempt in their lifetime. Chapter 5 is a qualitative study of the barriers men who are suicidal experience around accessing professional support. Chapter 6 is a Delphi study to develop research priorities to advance our understanding of male suicide risk and recovery. The thesis ends with a discussion in Chapter 7 of the empirical findings of the thesis, conclusions, limitations and ethical, clinical, and research implications.

Chapter 2: Methods

2.1 Overview

This chapter gives a brief overview of the rationale underpinning the methodological choices of this thesis. The chapter begins by introducing my position as a researcher to make explicit some of the lived experiences I bring to the process. I will then discuss the methodological decision for taking a mixed-methods approach, the selection of research designs and analyses, key constructs explored, and the ethical considerations when working with lived experience experts.

2.2 Reflexivity and positionality

It is now widely accepted that no researcher - whatever methods they use - can bring pure neutrality to their work (Elliott, Fischer, & Rennie, 1999; Malterud, 2001). Every human is the product of a cultural context where the stimuli of the world are imbued with different meanings according to the values of that society. The beliefs and values we inherit from our cultures shape how we are socialised and experience the world. Similarly, each of us has our own lived history of complex and diverse experiences that - conscious or not - inform how we see the world. Researchers are now encouraged to reflect upon and explain how some of these experiences may impact upon their work (Berger, 2015). Here, I seek to distil what I consider to be the most salient points from my lived experience to have shaped my researcher's lens.

2.2.1 Relationship to Men

As well as a younger sister, I grew up with three brothers, four of us, four years apart. I was nested in the company of men my entire childhood and adolescence and observed aspects of 'male' socialisation up close, such as emotional suppression, self-reliance, psychological inflexibility, protection, and risk-taking (Coleman et al., 2011; Levant, 1992). My strong bonds with my brothers gave me an ease in male company, and I have several significant long-standing friendships with men. I am also gay and believe my sexuality and gender give these dynamics a unique intimacy. My male friends are freed to some extent from the

constraints of masculine and/or sexual performance, and this freedom has potentially offered the men in my life the ability to speak to me candidly about their struggles. Many of the men I am close to have mental health challenges, and I have witnessed these struggles develop and the help-seeking behaviours and coping strategies utilised in response. These experiences have potentially afforded me a relatively unique and intimate window into the male experience particularly relating to mental health challenges.

2.2.2 My Relationship to Suicidal Thoughts and Behaviour

Suicidal thoughts and behaviours have moved in and out of my life differently at different times. However, the reason I became a suicide researcher was driven by my siblings experiencing debilitating mental health conditions, as well as thoughts of suicide, some intermittently, others consistently, over many years, which have also led to suicide attempts. Becoming a suicide researcher was driven by those experiences. I wanted to understand why people I love would see death as an answer to existence and uncover a better response for them by exploring what makes lives worth living. Kleiman et al. (2017) suggest that part of our lack of knowledge about suicide stems from our inability to "observe suicidal thoughts and behaviours "in the wild" as they occur in real time" (p. 727). My personal experiences mean I enter this research with many years of intimate experience observing and interacting with suicidal pain "in the wild" albeit within a very small sample. I have spent many hours in the company of suicidal distress. I have witnessed its transient, unpredictable, and consumptive nature, and the complex, exhausting struggle of attempting to regulate it. I've witnessed mental health spillovers for those caring for a person in suicidal pain. I've witnessed both our mental health system’s inadequacies to provide robust care and protection as well as my own. I've also witnessed, and continue to witness, the complex, uncertain, and fragile process of seeking to reclaim a dignified and meaningful existence.

2.2.3 Previous Research

I started this PhD after completing an MSc in 'Social and Cultural Psychology' in 2018. My dissertation topic was a qualitative study of male suicide comprising 32 interviews with men who were suicidal, and people bereaved by male suicide. This work inadvertently acted as what Swedberg (2020) terms an "informal exploratory study" (p.33). This type of study helps a researcher develop an understanding of a topic and decide "if she is on the trace of

something really new and interesting" that warrants further and fuller investigation (p. 33). My MSc findings suggested that specific pressures imbued in ideas of masculinity appeared to elevate men's suicide risk. In particular, the cultural diminishing of men's emotional lives, the shame associated with seeking help, and the social demonisation of suicidal feelings all seemed to compound the isolation of men in crisis. This thesis was borne of that work.

2.2.4 Impact on Research

My relationship with suicide and men impacts upon every aspect of my work, particularly in affording me a certain ease and compassion in coming alongside men struggling to stay in existence. Of course, as a female researcher, I can never understand what it is to move in the world as a man, and this limits the scope of my understanding (Berger, 2015). At best, this can sometimes enrich my work with a dual perspective. I can filter findings through my female-socialised lens and potentially observe different cultural affordances offered to each gender. I believe being an 'outsider' also enhances my sensitivity towards ensuring research participants are foregrounded as the topic 'experts' (Berger, 2015). Suicidology has lacked female representation. From 1989 to 2018, 72% of publications on suicide were authored by men (p. 8 Astraud, Bridge & Jollant, 2020). Gender norms influence all aspects of life, including scientific practice - the research questions explored, methodologies privileged, and the evaluation and interpretation of findings (Richardson, 2013). Male academics have dominated suicide research. As already noted, there has been a curious lack of qualitative work and studies explicitly focused on the gendered dimensions of male suicide. This has left critical, psychological dimensions of male suicide unexplored and underdeveloped. It is interesting to consider how gendered norms may have influenced this reality and how the social silencing of male emotionality may extend into suicide research. I believe women can make a valuable contribution to progressing our understanding of the cultural and psychological dimensions of male suicide whilst acknowledging that there will always be limits to a female researcher's ability to understand what it is to be a man.

Researching suicide can be an emotional endeavour. There have been moments where I have felt overwhelmed by the magnitude of suffering expressed by participants and the limitations of research to ease it meaningfully. I have lived with this sense of futility on a personal level for many years and experience it now on an academic scale too. Berger (2015) suggests peer support networks can be an important tool for reflection and being part of netECR - a

collective for early career suicide researchers - has provided important solidarity. As part of netECR, I and two others set up ‘Collective Care’, a monthly online peer support space where we meet to discuss the emotional challenges of researching this topic. This space has, at times, been invaluable.

Suicide is profoundly individual, and the danger of being close to the topic is that your biases and experiences cloud your interpretation of data. I have found the most effective corrective for this lies in a drive - however futile - for the work to make a difference. Fulfilling a desire to be useful necessitates meeting men in the complex diversity of their realities. Prioritising my experiences or sensitivities does not further that aim. It distorts it. I found the research process benefited from long periods of sitting with my analysis, reflecting on it, questioning my assumptions, talking to others, and always ensuring that my interpretations were led and evidenced by what was in the data. Similarly, my supervisors, collaborators, and peer reviewers have helped provide additional checks to verify the value of findings.

2.3 Rationale for Using a Mixed-Methods Approach

A mixed-methods approach was used to investigate the research aims of this thesis. Mixed-methods are recommended when investigating a complex topic, such as suicide, where results from one method may be insufficient to adequately explore relevant phenomena (Creswell & Piano Clark, 2018). Additionally, mixed-methods can be useful in exploratory studies, enabling researchers to employ flexible strategies during early explorations of a problem (Swedberg, 2020).

Mixed-methods research utilises both quantitative and qualitative designs. Different worldviews underpin these two methodologies, and these paradigms guide what researchers believe to be discoverable about the world, the methods they use to seek knowledge, and how researchers interpret and situate findings (Creswell & Piano Clark, 2018; Morgan, 2007). Like other research areas, psychological suicidology has often been polarised between these two methods (Goldney 2002; Leenaars, 2002). Quantitative researchers often believe that the causes of suicide can be discovered. In their work, they pursue an underlying, singular reality to explain suicidal behaviours. Their work is often driven by the assumption that we can develop generalisable principles to explain suicide, allowing us to make reliable predictions about who is at risk. Researchers within this paradigm use quantitative methods to distil

statistically verified, observable, generalisable "facts" regarding suicide. The desire to arrive at a discoverable truth concerning the human tragedy of suicide is understandable. As Thorne et al. (2004) describe, “in the immediacy of human suffering, we crave a path with signposts” (p. 1351). However, as already discussed, despite dominating research to date, quantitative work has failed to illuminate suicide with significant clarity.

Other researchers reject the quantitative paradigm because they believe the reality of suicide is not singular, but multiple; that suicide is a subjective behaviour, situated in individual bodies that are deeply entwined within ever-shifting temporal and dynamic social worlds (Hjelmeland, 2013). For these researchers, the causes of suicide are individual and social, and therefore, multiple; they can never be fully known - potentially even to the person dying. A qualitative paradigm is their preferred methodology. Rooted in a constructivist worldview, qualitative work understands reality as uniquely constructed by those experiencing it. As such, there is not a singular, objective reality to suicide waiting to be discovered by researchers. Instead, a constructivist approach focuses on exploring the subjective understandings and perceptions of the multitudes of people experiencing suicidal thoughts, feelings, and behaviours.

Mixed-methods reconcile these divergent paradigms by allowing for a worldview of pragmatism. Pragmatism is a flexible approach that does not get too distracted by ontological and epistemological questions - however valuable these are - but instead focuses on finding solutions to real-life problems (Creswell & Piano Clark, 2018; Morgan, 2007). Whether there is an underlying singular reality or multiple realities to suicide is a critical question, but at the same time, suicide is a real and urgent phenomenon in our world that requires pragmatic solutions. Accepting the limits of what we can know about suicidal behaviours, pragmatism calls for its researchers to be of utility within a paradigm of uncertainty. Many scholars now acknowledge that suicidology requires cross-disciplinary research (O'Connor & Kirtley, 2018; Shneidman, 1993). All methodologies have their strengths and weaknesses, and the lack of concrete progress in suicidology has led to a growing recognition that qualitative and quantitative researchers need to work together to utilise each other's strengths in support of enhancing our understanding of this painful human plight (Goldney, 2002; Greenhalgh et al., 2016; Hjelmeland & Knizek, 2010; Lester 2002; Ojagbemi, 2017). Employing a mixed-methods approach in this thesis allows us to utilise the strengths of both methods.

2.4 Overview of Studies

This thesis comprised four empirical studies, each of which employed different research designs and generated both quantitative and qualitative data. See Table 2.1 for a brief overview of all studies. Explanations of the methods and analytical approaches used in each empirical study are explored in their respective chapters. However, this chapter offers more context for the rationale underpinning each study design.

Table 2.1 *Overview of empirical studies*

Chapter	Study	Rationale	Description	Population	Analytical Approach
3	Study 1: Qualitative meta-synthesis and systematic review	To bring together and review the existing qualitative evidence-base on male suicide risk and recovery	Synthesised the male suicide qualitative literature, exploring risk and recovery factors across 20 years of research. From findings two novel models were developed to help understand male suicide risk and recovery - '3 'D' Model of Masculinity Norms and Male Suicide Risk' (3 'D' Risk) and '3 'R' Model of Male Suicide Recovery' (3 'R' Recovery)	78 qualitative studies with men who are suicidal, or people bereaved by male suicide	PRISMA guidelines for reporting systematic reviews of qualitative evidence (Moher et al., 2009) and thematic synthesis for qualitative research in systematic reviews (Thomas & Harden, 2008)
4	Study 2: Quantitative cross-sectional study	To explore in a cross-sectional study design some of the phenomena identified as important in the 3 'D' Risk model developed in Study 1	Investigated the relationship between phenomena relating to emotions, self, connections with others and suicide, identified in the '3 'D' Risk model as potentially relevant to male suicide risk.	Sample of 2,763 from the general population	Multinominal logistical regression
5	Study 3: Qualitative thematic analysis	Men are less likely to seek professional help. Professional support can prevent a suicide crisis from escalating. This study aimed to identify barriers men who are suicidal experience around accessing professional support	Investigated the barriers men who are suicidal experience accessing professional support and mapped these to Michie et al. (2011) behaviour change wheel	Sample of 725 men who have had thoughts of suicide or men who have attempted suicide in the past week or year, from the general population	Thematic analysis (Braun and Clarke, 2006)
6	Study 4: Modified Delphi	Data from Study 1, 2 and 3 indicated many crucial directions for further research, this study helped develop priorities to guide the next iteration of male suicide research work	Developed research priorities for male suicide research	Sample of 242 men who have had thoughts of suicide, men who have attempted suicide, and people bereaved by male suicide from the general population; 10 male academic/clinical experts	Modified Delphi methodology for mental health research (Jorm, 2015)

2.4.1 Study 1: Qualitative Meta-Synthesis and Systematic Review

As described in Chapter 1, quantitative work has dominated the field of suicide research. While this body of research has produced important insights, it can only yield an incomplete view of behaviour as complex as suicide. Critical gaps exist in our understanding of the psychological pathways underpinning male suicide risk and recovery. Numerous scholars have spoken of the importance of qualitative work to bring us closer to the lived experience of suicidal pain, from which we can generate richer hypotheses and enhance theory (Fitzpatrick, 2011; Scourfield, 2005). Similarly, in exploratory research, when the critical phenomena involved in a behaviour may not yet be known, qualitative work is recommended to generate potential theories that can then be tested quantitatively (Creswell & Piano Clark 2018). Given the gaps in our knowledge and the exploratory nature of this thesis, it felt pertinent to conduct a qualitative meta-synthesis and systematic review of the existing qualitative male suicide literature.

2.4.1.1 Rationale for Qualitative Meta-Synthesis and Systematic Review

Systematic reviews are an effective tool for amalgamating and synthesising findings across a large body of evidence and highlighting areas of priority for future research. As the quality and production of qualitative research have grown, qualitative meta-synthesis has become an increasingly popular tool for reviewing evidence bases (Lachal et al., 2017; Lewin & Glenton, 2018; Newman et al., 2006; Thomas & Harden, 2008). A qualitative meta-synthesis can increase the generalisability, credibility, and validity of qualitative work by providing a triangulation of results across multiple studies (Finfgeld, 2003).

I did not know what insights the existing qualitative evidence base on male suicide would yield. However, it was hoped that - if sufficiently rich - it could help generate potential hypotheses of psychological pathways underpinning male suicide risk and recovery and deepen our understanding of the potential relationship between male gender, male psychology, and male suicide. As such, this study aimed to explore how men who are suicidal, and people bereaved by male suicide understand suicide risk and recovery factors by synthesising key findings from 20 years of qualitative studies.

Various steps were undertaken to ensure the review followed robust methodological principles and the PRISMA guidelines (Moher et al., 2009) for reporting systematic reviews of qualitative evidence were adhered to throughout. Together with an expert librarian, an exhaustive, systematic search strategy was developed. During the title and abstract screening, 20% of papers were randomly selected, stratified by year of publication, and independently screened by two reviewers, to ensure rigor and reliability. The NICE Quality appraisal checklist was used to assess the quality of each study selected for the review (NICE, 2012). A second reviewer coded 20% of the final papers to verify the thematic framework and regular consensus meetings were held with the author and supervisory team to discuss the thematic framework (Lachal et al., 2017).

2.4.2 Study 2: Quantitative Cross-Sectional Study

A strength of the mixed-methods approach is that it allows researchers to combine inductive theoretical observations from qualitative work with deductively testing these findings in a quantitative study (Malterud, 200; Morgan, 2007). To that end, the design of this cross-sectional study was based on the theoretical insights from the qualitative meta-synthesis and systematic review.

2.4.2.1 Rationale for Quantitative Cross-Sectional Study

The qualitative meta-analysis identified that masculine norms relating to male emotional suppression, failing to meet standards of male success, and the devaluing of men's interpersonal needs appeared to be associated with increased distal/proximal suicide risk. A '3 'D' Risk' model to represent these findings was developed. This cross-sectional study (Chapter 4) builds on these findings to explore the phenomena of the model in a cross-sectional sample aimed at exploring what factors potentially differentiate men who are not suicidal, from men with lifetime thoughts of suicide, and men who have made a lifetime attempt. As the study aimed to explore a wide range of measures and psychological domains, a cross-sectional study design felt most appropriate, allowing data to be collected from a large and diverse sample.

2.4.2.2 Rationale for Sample

Seager and Barry (2019) caution that while suicide research into specific subpopulations of men, i.e., bisexual men, is valuable because of unique risk factors that may relate to that demographic, it is still important to examine the role of male gender as a broader, collective identity, in male suicide. To that end, and given the exploratory nature of this work, inclusion was kept broad. Identifying as male and being aged 18 or older were the only inclusion criteria. The survey was open to participants worldwide and men from 79 countries responded. In keeping with previous research, Western men still dominated the sample (O'Connor & Nock, 2014).

2.4.2.3 Rationale for Analysis

To explore differences between men who are not suicidal, men with lifetime thoughts of suicide, and men who have made a lifetime suicide attempt, multinominal logistical regression models were run. Model 1 explored: (a) men who are not suicidal (reference: not suicidal) vs men with thoughts of suicide (ideation); and (b) men who are not suicidal (reference: not suicidal) vs men who have attempted suicide (attempt). Model 2 compared (c) men with thoughts of suicide (reference: ideation) vs men who have attempted suicide (attempt). Separate multinomial univariate logistic regression analyses were conducted for each variable in each model to determine which variables would be included in the multivariate analysis. Variables that were significant in the univariate analysis ($p<.01$) were included in the multivariate analysis. A risk factor was deemed to be significant in the multivariate analysis if the p-value was <0.01. The p-values were set at this level to account for multiple comparisons. Odds ratios (OR) and 95% CIs were reported for both the univariate and multivariate analysis. All analyses were conducted using R version 4.2.2.

2.4.3.4 Rationale for Psychometric Measures

The following section outlines the rationale for the variables selected for this study. For a full breakdown of each scale selected, see Table 2.2. A full copy of each scale can be found in Appendix 4.3.

Table 2.2 *Overview of constructs*

Theme: Emotions and Psychological Pain

Phenomena	Measure	Sub-Scales	Items	Item Example	Item Scoring	Cronbach Alpha (α)	Measure Scoring	Score Interpretation
Depression	Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	0	9	'Over the last 2 weeks, how often have you been bothered by the following problems? Feeling tired or having little energy'	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day	α = 0.89 and 0.86 (Kroenke, Spitzer & Williams, 2001)	Count each reply of '0' and multiply it by 0; count each reply of '1' and multiply it by 1; count each reply of '2' and multiply it by 2; count each reply of '3' and multiply it by 3; total	Higher scores indicate higher levels of depression
Psychological Pain	2 sub-scales (Flooding and Freezing) from Mental Pain Scale (Orbach et al., 2003)	2 = Flooding (FL) & Freezing (FR)	7 – FL, 4; FR, 3	FL = 'I am flooded by many feelings.' FR = 'I feel paralyzed.'	1 = Does not describe me at all ... 5 = Describes me very well	FL α = 0.93 FR α = 0.85 (Orbach et al., 2003)	Sum of each sub-scale	Higher scores indicate higher levels of pain
Entrapment	Entrapment Scale (De Beurs et al., 2020)	2 = Internal Entrapment (IE) & External Entrapment (EE)	4 – 2 per sub-scale	IE= 'I feel trapped inside myself' EE= 'I often have the feeling that I would just like to run away.'	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me	α = 0.87; IE α = 0.78; EE α = 0.82 (De Beurs et al, 2020)	Sum of each sub-scale	Higher scores indicate higher levels of entrapment
Defeat	1 sub-scale (Defeat) from Defeat & Entrapment Scale (Griffiths et al., 2015)	0	4	'I feel defeated by life'	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me	α = 0.77 – 0.80 (Griffiths et al., 2015).	Sum of scale	Higher scores indicate higher levels of defeat
Emotional Control & Self Reliance	2 sub-scales (Emotional Control and Self Reliance) from Conformity to Masculine Norms (Mahalik et al., 2020)	2 = Emotional Control (EC) and Self Reliance (SR)	6 – 3 per subscale	EC = 'I tend to share my feelings' SR = 'I never ask for help'	1. Strongly Disagree; 2. Disagree; 3. Slightly Disagree; 4. Slightly Agree; 5. Agree; 6. Strongly Agree	EC α = .90 and 0.71 SR α = .78 (Mahalik et al., 2020)	Reverse 4 items; sum of each sub-scale	Higher scores indicate higher levels of emotional control and self-reliance
Attitudes to Emotional Expression	Attitudes towards Emotional Expression scale (Joseph et al., 1994)	4 = Beliefs about meaning (Sign of Weakness) (BAM); Behavioural Style (Bottle Up) (BS);	20 – 5 per sub-scale	BAM = 'I think getting emotional is a sign of weakness.' BS = 'When I'm upset, I bottle up my feelings' BAE = 'You should always hide your feelings.' BAC = 'If other people know what you are really	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree	BAM α = 0.85; BS α = 0.88; BAE α = 0.82; BAC α = 0.70 (Joseph et al., 1994)	Reverse 1 item; sum of each sub-scale	Higher scores indicate higher levels of restrictive attitudes to emotional expression

		Beliefs about expression (keep in control) (BAE) Beliefs about consequences (social rejection). (BAC)		like, they will think less of you.'				
Theme: Feelings Towards Self								
Variable	**Measure**	**Sub-Scales**	**Items**	**Item Example**	**Item Scoring**	**Cronbach Alpha**	**Measure Scoring**	**Score Interpretation**
Failure	1 item (Failure) from Beck Depression Inventory (BDI-II; Beck, Steer & Brown, 1996)	1	1	'Pick one statement that best describes the way you have been feeling during the past two weeks, including today.'	1. I have failed more than I should have. 2. As I look back, I see a lot of failures. 3. I feel I am a total failure as a person.	α = 0.73 to 0.96. (Wang & Gorenstein, 2013)	Sum of sub-scale	Higher scores indicate higher levels of perceived failure
Self-Esteem	Self-Esteem Scale, (Rosenberg, 1965)	0	10	'On the whole, I am satisfied with myself'	1. Strongly Agree; 2. Agree; 3. Disagree; 4. Strongly Disagree	α = usually above .80 (Donnellan, Trzesniewski & Robins, 2015)	Reverse 5 items; Sum of scale	Higher scores indicate lower levels of self-esteem
Self-Liking and Self-Competency	Self-Liking/Self Competence Scale (Tafarodi & Swann, 1995)	2 = Self-Liking (SL) & Self Competence (SC)	16 – 8 per sub-scale	SL = 'I never doubt my personal worth' SC = 'I perform very well at many things'	1. Strongly Agree; 2. Agree; 3. Disagree; 4. Strongly Disagree	Self-liking α reported between .70 and .98, and for self-competence α from .56 to .92 (Donnellan, Trzesniewski & Robins, 2015).	Reverse 8 items; sum of each subscale.	Higher scores indicate lower levels of self-liking and self-competency
Theme: Connections with Others								
Variable	**Measure**	**Sub-Scales**	**Items**	**Item Example**	**Item Scoring**	**Cronbach Alpha**	**Measure Scoring**	**Score Interpretation**
Perceived Social Support	The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	3 = Significant Other (SO); Friends (FRI); Family (FAM)	12 – 4 per sub-scale	SO = 'There is a special person with whom I can share my joys and sorrows' FRI = 'I can count on my friends when things go wrong' FAM = 'I can talk about my problems with my family'	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree	SO α = .91; FRI α = .85; FAM α = .87; (Zimet et al., 1988)	Sum of each sub-scale	Higher scores indicate higher levels of perceived social support
Mattering to Others	General Mattering Scale (Marcus, 1991)	0	5	'How important are you to others?'	1. Not at all; 2. A little; 3. Somewhat; 4. Very much	α = .76. (Sarı & Karaman, 2018)	Sum of Scale	Higher scores indicate higher levels of mattering to others

Loneliness	The De Jong Gierveld 6-Item Scale Loneliness Scale (Gierveld & Van Tilburg, 2006)	2 = Emotional Loneliness (EL) & Social Loneliness (SL)	6 – 3 per sub-scale	EL = 'I miss having people around me' SL = 'There are many people I can trust completely'	1. Yes!; 2. Yes; 3. More or less; 4. No; 5. No!	EL α = .67 and .74. SL α = .70 and .73 (Gierveld & Van Tilburg, 2006)	For EL count responses that were either 1, 2 or 3 and give each a value of 1. For SL count responses that were either 5, 4 or 3 and give each a value of 1.	Higher scores indicate higher levels of loneliness

2.4.3.4.1 Emotions and Psychological Pain Measures

In the qualitative meta-synthesis, 92% of papers showed evidence for a potential association between norms of male emotional suppression, emotional dysregulation, and male suicide risk. Some men perceived emotional expression as burdening others, a sign of weakness, and/or that men needed to be emotionally self-reliant. At the same time, men described feelings of overwhelming psychological pain, defeat, and entrapment. These findings suggest that men who are suicidal may experience a high level of emotional dysregulation and hold potentially restrictive attitudes towards emotional expression. To explore this relationship, the scales in this cluster were selected to examine: 1) men's current emotional state, i.e., rates of depression, entrapment etc., and 2) attitudes towards expressing and managing emotion.

2.4.3.4.2 Feelings Towards Self

In the qualitative meta-synthesis, 76% of studies suggested that feelings of failure appeared to be associated with increased psychological pain and suicide risk in men. Men who are suicidal described aversive self-awareness and low self-esteem. This cluster of scales, explored men's feelings and attitudes towards themselves, including feelings of failure, self-esteem, self-liking, and self-competency.

2.4.3.4.3 Connections with others

In 82% of studies from the qualitative meta-synthesis, evidence suggested masculine norms that devalue and suppress men's interpersonal needs were associated with denial, disconnection, and dysregulation in some men's interpersonal dynamics. Intolerable isolation and loneliness were described by many men who are suicidal. This cluster of scales explored men's sense of mattering to others, their social and emotional isolation, and connections with a significant other, friends, and/or family.

2.4.3.4.4 Suicide

To measure participants' history of suicidal behaviours, two items were used from the Adult Psychiatric Morbidity Survey (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2007). To measure past thoughts of suicide, participants were asked: 'Have you ever thought of

taking your life, but not actually attempted to do so?' To measure past suicide attempts participants were asked: 'Have you ever made an attempt to take your life?'

2.4.3 Study 3: Qualitative Study

Evidence suggests that men are less likely to access professional support for suicidal distress (Tang et al., 2022). Understanding men's reluctance to get help is an essential component of suicide prevention for men as effective help-seeking can potentially prevent a suicidal crisis from escalating (Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2015).

2.4.3.1 Rationale for Qualitative Study

The literature concerning men's help-seeking for psychological problems is recent and primarily quantitative, and scholars have highlighted a need for richer insights from men themselves (Hoy, 2012). Given the pragmatic nature of this exploratory thesis, prioritising a better understanding of the barriers men experience around accessing professional support felt important. Exploring these challenges could help policymakers, service providers, and researchers develop more effective professional interventions for men. More effective interventions for men in crisis could prevent more deaths.

As part of the cross-sectional study documented above, a set of questions was designed to qualitatively explore men's barriers to accessing professional support. Participants were initially asked: "How likely would you be to seek professional help for your mental health if you felt you needed it right now?" and could respond using a 3-point Likert scale of 'Not likely', 'Somewhat likely', 'Very likely.' Participants were then asked: "If you answered that you would not be likely, what would be some of the barriers to you accessing professional support?" Responses varied from a single word to multiple paragraphs. Most participants wrote at least several lines. This study is an analysis of their responses.

2.4.3.3 Rationale for Sample

To prioritise learnings on the barriers for men who are suicidal to accessing professional support, only responses from men who had experienced thoughts of suicide and/or attempted suicide in the past week or year were included.

2.4.3.4 Rationale for Thematic Analysis

There are various methods used to analyse qualitative data. Given that this was a large set of data (n=725) from an open-text survey question where responses varied in length, a thematic analysis felt the most pragmatic approach. Thematic Analysis (TA) is a tool for exploring and interpreting perceived patterns and themes within data (Braun & Clarke, 2006). TA is a flexible methodology, with its authors encouraging researchers to use the framework as "an invitation, a springboard" (p. 431, Braun, Clarke, & Hayfield, 2022). As such, researchers are encouraged to use TA principles flexibly according to what works best for their data and approach. For this analysis, an inductive approach was utilised, whereby the thematic framework was developed in response to the themes identified in the data instead of a particular framework or theory being applied to responses. The nature of open-text responses means both a latent and semantic approach was required. Some responses were quite short i.e., "financial" or "shame" and could only yield a latent reading of meaning. Other longer-form responses allowed for a more semantic approach whereby a deeper reflection on potential subtexts and higher-order meanings could be considered.

2.4.5 Study 4: Modified Delphi Study

Exploratory research can often raise more questions than it answers (Swedberg, 2020). One of the purposes of this exploratory thesis was to deepen our understanding of the psychological phenomena underpinning male suicide risk and recovery. In reviewing the data amassed from studies 1, 2 and 3, it became clear that there were many urgent areas that would require future investigation, i.e., emotional suppression and male suicide risk, loneliness and male suicide risk. However, there are limited resources to fund research and limited researchers to deliver the work. In order to advance the field, it felt important to define the next set of research priorities for male suicide. This Delphi study worked with lived-experience participants and global academic/clinical male suicide experts to define an agenda of research priorities to take forward male suicide work.

2.4.5.1 Rationale for Modified Delphi Study

The Delphi is a decision-making tool that extracts the views of multiple 'experts' in a systematic way to build consensus (Jorm, 2015). A group of people with some claim of expertise on a subject, rate statements via survey rounds. A statistical threshold is set to signify when consensus amongst these experts has been met, with opportunities for experts to review their decisions based on the responses of others (Jorm, 2015). The Delphi methodology is predicated on the principle that a diverse group of experts will generate better quality decisions than individuals or homogenous samples (Saini, Clements, Gardner, Chopra, Latham, Kumar, & Taylor, 2020). The Delphi methodology is useful when "a consensus of values is needed" (Jorm, 2015, p. 895), such as developing a research agenda. For this study, a two-step modified Delphi method was used to establish consensus around research priorities.

2.4.5.1 Rationale for Sample

The Delphi technique is predicated on building *expert* consensus. A key question was therefore who would constitute an 'expert' within this study (Jorm, 2015). Different Delphi studies work with different expert groups, including researchers, policymakers, funders, service providers, carers, clinicians, service users, and lived-experience experts. Scholars note that researchers and funders have often set healthcare research agendas and that lived-experience experts need to be more involved to ensure research asks questions pertinent to the people living the phenomena (Iqbal, West, Haith-Cooper & McEachan, 2021). The original items for the proposed agenda were based on academic research and grey literature. As such, items for the research agenda were drawn from the collective expertise of academic and NGO researchers, policymakers, and clinicians. Therefore, it felt appropriate to give decision-making power to lived-experience experts to decide from within the academically informed raw material of the agenda which questions should be prioritised. An advisory panel of academic/clinical experts were recruited to support the agenda's development and triangulate the perspectives of expertise across both professional and personal domains.

2.5 Ethical Considerations and Participant Safety

All the studies with participants were approved by the research ethics committee of the College of Medical, Veterinary, and Life Sciences of the University of Glasgow (Study 2 and 3: application No. 200200085; Study 4: application No. 200200128)

Each study was carefully designed to minimise distress or harm to participants. It is important not to assume that discussing suicide will have a detrimental effect on participants. As Fitzpatrick (2014) suggests, there is a danger in viewing suicidal people as "emotionally fragile" and not as "creditable and valuable sources of knowledge" (p. 157). Fitzpatrick warns that doing so means we can exclude people who are suicidal from our work, leaving our understanding of suicide narrowed to the intellectual outputs of professionals. There is a robust body of research that suggests no negative impact on participants' well-being when asked about suicide and that it can sometimes reduce, rather than increase, suicidal ideation (Dazzi, Gribble, Wessely, & Fear, 2014; Lakeman & FitzGerald, 2009; Omerov, Steineck, Dyregrov, Runeson, & Nyberg, 2013; Reynolds, Lindenboim, Comtois, Murray, & Linehan, 2006).

Whilst participating in research may be beneficial, it is still important that studies are carefully designed to reduce potential harm. For this thesis, various steps were taken to help ensure this. A group of lived experience experts known to the researcher helped pilot and review each study component shared with participants, to ensure clarity, accessibility, and sensitivity of materials, i.e., recruitment adverts, recruitment website, survey, participation, and information sheets. The recruitment process for each study was intentionally designed to allow participants time and information to make the right decision for themselves about their involvement. For studies 2 and 3, the 'Participation and Information' sheet was available on the survey's homepage. Participants were also informed that they could save their responses and come back to the survey at another time and that they did not have to answer any questions that made them distressed and were free to withdraw from the study at any time without penalty. On the screen with questions about suicide, at the top of the page, participants were warned about the nature of the questions to come and support lines provided. The survey also closed with a debrief and a list of support organisations and relevant contact details.

Similarly, for study 4, a recruitment website was built. From the study advert, participants were referred to this site where they could read in full about the purpose of the study. The

website included an overview of the study, a copy of the 'Participation and Information sheet', background on the research team, and signposting to support services. People with lived experience reviewed the website to ensure sensitivity of tone and clarity/accessibility of information. From the website, participants could self-select involvement in the study by submitting an online expression of interest via a form on the site. Participants were also routinely informed throughout the study that they could withdraw at any time.

Chapter 3 "Male Suicide Risk and Recovery Factors: A Systematic Review and Qualitative Q1 Metasynthesis of Two Decades of Research"

3.1 Abstract

Objective: Suicide is a gendered phenomenon, where male deaths outnumber those of women virtually everywhere in the world. Quantitative work has dominated suicide research producing important insights but only a limited understanding of why more men die by suicide. A qualitative meta-synthesis and systematic review of 20 years of narratives from men who are suicidal, and people bereaved by male suicide, was conducted to identify putative risk and recovery factors.

Methods: Following the inclusion and exclusion criteria, 78 studies that encapsulated insights from over 1,695 people were identified. Using Thomas and Harden's Thematic Synthesis Method, our analysis is built on 1,333 basic codes, 24 descriptive themes and four analytical themes.

Results: An association between cultural norms of masculinity and suicide risk was noted in 96% of studies. Norms relating to male emotional suppression, failing to meet standards of male success, and the devaluing of men's interpersonal needs appeared to be associated with dysregulated psychological pain and suicide risk. While recognizing that masculinity is not pathological, findings suggest that the interaction and accumulation of cultural harms to men's emotions, self, and interpersonal connections may potentially distinguish men who are suicidal from men who are not. Supporting men to understand and regulate emotions and suicidal pain, expanding possibilities for masculine identity, and building meaningful interpersonal connections were reported as helping support recovery from suicidal crises.

Limitations: Sample data was predominantly White, cis-gendered, and English speaking, and the underlying research designs prevent strong causal inferences.

Conclusion: Two novel models are proposed to help understand male suicide risk and recovery built upon the reciprocal dynamic between cultural norms of masculinity and their impact on the emotions, self-concept, interpersonal connections, and psychological pain of men who are suicidal. Findings suggest 7 recommendations for future theoretical exploration of male suicide, and 22 research recommendations.

3.2 Introduction

Suicide is one of the most complex human behaviours to understand, transgressing our biological drives to survive and reproduce, and the cultural idea of existence as sacred (Aubin et al., 2013; Perry, 2014; Ringel, 1976; Soper, 2019). An estimated 703,000 people die by suicide each year (WHO, 2021), with millions more attempting, planning or thinking about suicide (Centers for Disease Control and Prevention, 2021). In the United States, 37,256 men died by suicide in 2019 (Centers for Disease Control and Prevention, 2021) and death by suicide was 3.63 times more common in men than women in 2019 (American Foundation for Suicide Prevention, 2021). In the UK, three-quarters of all suicides in 2018 were male (Samaritans, 2019). The scale of male suicide means investigations into its causes and ways to reduce its prevalence, are urgent.

3.2.1 Critical Qualitative Gaps in Suicide Knowledge

Establishing reliable suicide risk factors is vital for the development of effective theory, clinical assessments, and prevention interventions (Franklin et al., 2017). Quantitative and epidemiological studies have dominated suicide research to date (Chandler, 2019; Richardson et al., 2021). This work has yielded important insights and generated multiple suicide risk factors such as perfectionism (O'Connor & Nock, 2014) and substance abuse (Richardson et al., 2021). However, Franklin et al.'s (2017) meta-analysis of 50 years of suicide research suggests the predictive power of suggested risk factors are only slightly better than chance. Despite the proliferation of identified suicide risk factors, we still have no reliable way of identifying who is most at risk (Danchin et al., 2010; Franklin et al., 2017).

To move the field forward, researchers have called for a deeper understanding of the psychological pathways that underpin suicide risk, including understanding how risk factors interact (Bryan & Rudd, 2016; Glenn et al., 2017; Klonsky & May, 2015; O'Connor & Nock, 2014). Qualitative work has been identified as a way to contextualize risk factors identified by quantitative research and fill potential gaps in our collective knowledge (Chandler, 2012; Kryinska, 2014; O'Connor & Kirtley, 2018; Tang et al., 2022; Toomela, 2007). These gaps include the role of gender in suicide (Payne et al., 2008; Scourfield, 2005) - despite the higher rates of male deaths, gender has often been taken as a given and not robustly examined as a

potential contributory factor (Lee & Owens, 2002; Swami et al., 2008); the role of male emotional distress (Ridge et al., 2011); and the role of social and cultural contexts (Hjelmeland & Knizek, 2010; Samaritans, 2012; White, 2015). Understanding how culturally situated norms of masculinity and meaning systems are internalized and impact upon the psychology of men who are suicidal is vital (White, 2015). Qualitative work can potentially provide a richer contextualization for how suicidal thoughts, feelings, and behaviours emerge in individual minds and how cultural ideas affect an individual's psychology (Hjelmeland & Knizek, 2010; Lee & Owen, 2002).

The need for qualitative work is not to diminish the valuable contributions quantitative work has yielded (Fitzpatrick, 2011; Kral et al., 2017), nor to eulogise the contributions that qualitative work can make (Bantjes & Swartz, 2017). Like other areas of research, psychological suicidology has often been polarized between quantitative and qualitative methods (Goldney, 2002; Leenaars, 2002). However, suicidology requires cross-disciplinary research (O'Connor & Kirtley, 2018; Shneidman, 1993). Both, quantitative and qualitative methodologies have strengths and limitations. Quantitative methods provide validity, reliability, and generalisability in ways that cannot be directly replicated by qualitative work (Noble & Smith, 2015). However, quantitative work has been criticized for producing fragmentary lists of facts that, whilst valuable, do not always help explain underlying psychological processes (Hjelmeland & Knizek, 2010; Tang et al, 2022; Toomela, 2007). Qualitative work can yield in-depth data about the psychological mechanisms that drive suicidal behaviours, richly informed by the perceptions, experiences, and understandings of those with lived experience, generating theories and hypotheses to be tested by future work across all methodologies (Elliott et al., 1999; Hjelmeland & Knizek, 2010; Lester, 2002; Ojagbemi, 2017). However, small sample sizes mean results can be too subjective to offer generalizable conclusions (Fitzpatrick, 2011; Leenaars, 2002). In summary, reliance on a single research method can only provide an incomplete view of any behaviour, especially one as complicated as suicide, and all scientific methods are required to thoroughly examine its emergence (Bantjes et al., 2017; Canetto et al., 2012; Cleary, 2012; Hjelmeland & Knizek, 2010; Leenaars, 2002, Scourfield, 2005; Shneidman, 1993). The lack of qualitative work exploring male suicide has left vital gaps in our collective knowledge that require urgent attention (O'Connor et al., 2018).

3.2.2 Qualitative Meta-Synthesis to Help Fill Knowledge Gaps

As the demand for more qualitative work in suicidology increases there is a need to bring together the existing evidence base. To our knowledge, there has been no published qualitative meta-synthesis of male suicide research. Over the last 20 years, methodological guidelines for qualitative research have been developed to improve credibility and quality by setting standards for various procedures such as transparency of methods and analysis, reflexivity - making clear the role of the researcher and context in influencing data collection and interpretations - as well as evaluating the utility of findings and how much they explain and contribute to knowledge-bases (Grbich et al., 2008; Malterud, 2001; Mays & Pope, 2000; Noble & Smith, 2015; Stenfors et al., 2020). These methodological improvements have increased demand for qualitative meta-synthesis which review qualitative evidence bases (Lachal et al., 2017; Lewin & Glenton, 2018; Newman et al., 2006; Thomas & Harden, 2008).

To advance the male suicide research field, this qualitative meta-synthesis aims to synthesize how men who are suicidal, and people bereaved by male suicide understand male suicide risk and recovery factors across 20 years of research, in order to create a framework for what is already known and elucidate directions for future work (Levitt, 2018). Our research question was as follows: What are the potential common themes and psychological phenomena underpinning male suicide risk and recovery as perceived and experienced by men who are suicidal, and people bereaved by male suicide?

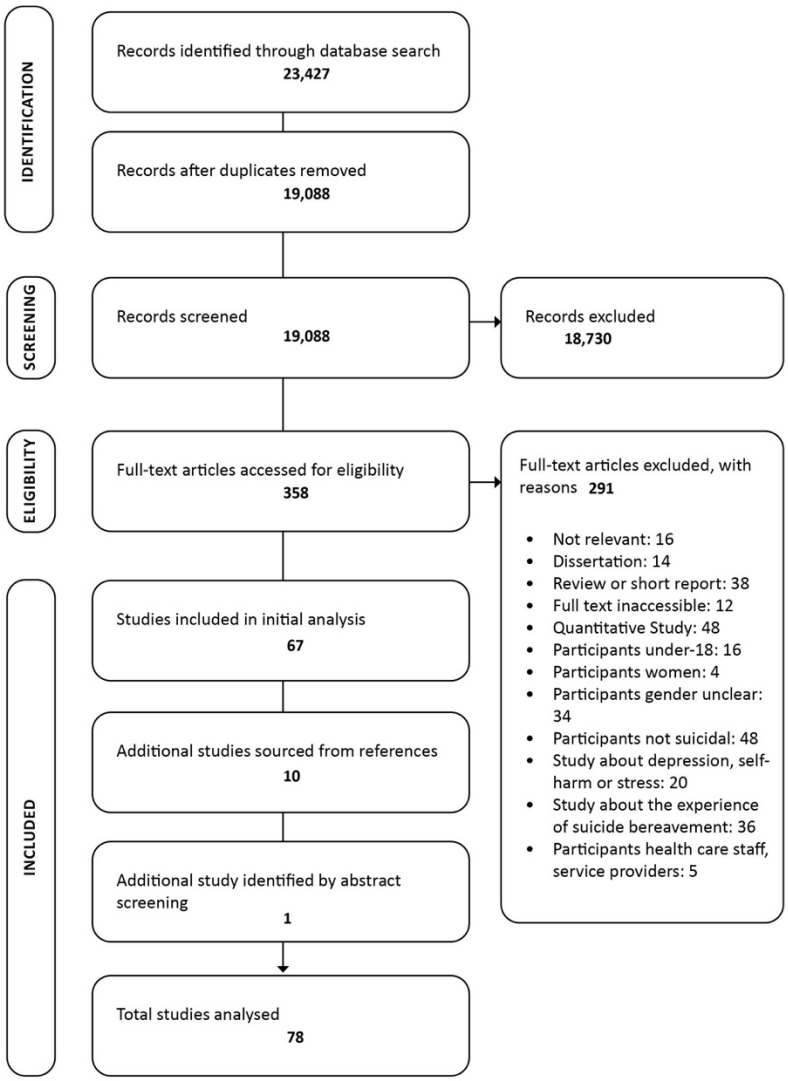
3.3 Methods

3.3.1 Study Design

This review adheres to the PRISMA guidelines (Moher et al., 2009) for reporting systematic reviews of qualitative evidence (Figure 3.1). Various approaches to qualitative meta-synthesis have been proposed and there is some conceptual blurring in the procedural literature, with practitioners often modifying processes (Paterson, 2012; Willig & Wirth, 2018). Researchers suggest that given the complexity of undertaking a qualitative meta-synthesis, methodological flexibility is necessary and tailoring methods to fit the needs of each review appropriate (Levitt, 2018) so long as researchers ensure their process is clearly and robustly

documented (Xu, 2008). To that end, a full account of the processes used in this study are given here and make available in the following data depository for future scrutiny and replicability (Xu, 2008):
https://supp.apa.org/psycarticles/supplemental/bul0000397/bul0000397_supp.html

Figure 3.1 *PRISMA flow chart*



3.3.2 Reflexivity and positionality

It is widely accepted that researchers cannot bring pure neutrality to their work therefore it is important to disclose potential biases (Elliott, Fischer and Rennie, 1999; Malterud, 2001).

The lead author of this study has loved ones who experience debilitating mental health conditions, as well as thoughts of suicide which have also led to suicide attempts. Other members of the research team, who were a mixture of mixed-methods clinical and health psychologists, have been personally bereaved by male suicide. The proximity to the research topic carries the risk, therefore, of personal biases influencing the interpretation of the data. In recognition of our own implicit and explicit biases, we employed a rigorous methodological approach - documented here - to ensure the validity and reliability of our findings, triangulated through multiple co-authors, reviewers and the journal editor. Attride-Stirling (2001) notes that qualitative analysis is always a subjective endeavour and different interpretations can arise from the same data. Nonetheless, we believe our interpretation is rigorously supported by the review data. This study aims to produce useful insights to enhance our understanding of male suicide by striving to accurately represent the complex diversity of experiences evident within the studied population.

3.3.3 Search Strategy

The purpose of this review was to capture what is known about male suicide, and so an inclusive search strategy was opted for that seeks to capture as much available data as possible within certain parameters (Timulak, 2009). Together with an expert librarian an exhaustive, systematic search strategy was developed. Searches were undertaken on Web of knowledge Core Collection and EBSCO Host on seven key databases: CINAHL, Medline, PsycARTICLES, Psychology and Behavioral Sciences Collection, PsycINFO, SocINDEX with Full Text, Web of Science: Core Collections. Siddaway, Wood and Hedges (2019) suggest that search terms and inclusion and exclusion criteria be relevant to the research questions, key variables, participants, and research design, and this guidance informed our search strategy development. Searches of indexed terms, titles and abstracts were based on derivatives of the key variables' 'men' AND 'suicide' AND 'qualitative OR mixed methods.' Each database had bespoke indexed terms and so a targeted search strategy was developed for each database (Lachal et al., 2017). See Appendix 3.1 for complete search strategy.

3.3.4 Inclusion and Exclusion Criteria

Studies included in this review had to meet the following criteria: i) English language research published in the last 20 years in peer-reviewed journals; ii) Qualitative or mixed-

methods research conducted anywhere in the world; ii) Participants aged 18 and over; iii) Participants included men who have experienced suicidal thoughts/feelings/attempts and/or people bereaved by male suicide. Excluded were quantitative studies, research where participants were only women who are suicidal or people bereaved by female suicide, as well as dissertations, reviews, and short reports.

3.3.4.1 Rationale for Exclusions

Around the turn of the century, scholars such as Elliott, Fisher and Rennie (1999) and Yardley (2000) produced critical reflections and guidelines to improve the credibility and quality of qualitative work, with previous research considered weak in terms of rigor and transparency of process and analysis. A 20-year cut off was imposed on the data to acknowledge the heralding of these methodological improvements and to try to maximize appropriate quality within our sample. Like other qualitative meta-synthesis, we only sourced English language papers for practical reasons as this was the only language of the first author (Xu, 2008). Timulak (2009) recommends only published data be used in qualitative meta-synthesis as a form of quality control. We followed this protocol and excluded dissertations, in keeping with other qualitative meta-synthesis work (de Vos et al., 2017; Lachal et al., 2015). We acknowledge there may be valuable findings in non-English, and unpublished work, and these are potential inclusions for future review work. Siddaway et al. (2019) strongly advise against using the NOT search operator "because it can have odd implications for search results" (p. 760). For this reason, we focused on studies that specifically included men rather than a strategy that focused on excluding women. Again, it is possible we missed studies this way. The decisions made are illustrative of potential gaps in all search strategies. Thomas and Harden (2008) note that it is important to remember that while a quantitative meta-analysis needs to locate all studies to create accurate statistical insights, with a qualitative meta-synthesis, there is not the same urgency to source every potential paper on a topic. A qualitative meta-synthesis is seeking to establish a "conceptual synthesis" which is achieved when findings don't differ whether six or twelve papers are included, if the same concepts are found in all the studies included in the sample (p. 3, Thomas & Harden, 2008). Thomas and Harden (2008) acknowledge that how this principle of conceptual synthesis gets applied is unclear, with a review team having to decide whether they have sourced sufficient studies to form a coherent analysis. We believe the papers sourced for our review have allowed us to achieve this goal. However, like other qualitative meta-synthesis, we

acknowledge potential gaps in our search strategy not least because, like Levitt et al. (2016) note from their meta-study, the broad way in which qualitative papers have been indexed means it would be rare for every relevant study to be sourced.

3.3.5 Screening

A scoping search was conducted on January 14, 2020, and the review was then registered on PROSPERO (CRD42020166686) before the official screening process began. Databases were searched on February 10, 2020. A total of 23,427 papers were extracted to ENDNOTE; 4,339 duplicates were removed, and the remaining 19,088 papers were screened by the first author (A1) for eligibility by title and abstract, removing 18,730 studies. To ensure rigor and reliability in the selection process, 20% of the abstract and titles were randomly selected, stratified by year of publication, and independently screened by two reviewers (A2 & A3). A2 and A3 screened a total of 3,812 references for inclusion in the study (pair one: n = 1,905, pair two: n = 1,907). Cohen's kappa was used to measure the inter-rater reliability of the screening process. The analysis revealed a kappa coefficient of 0.50 (95% CI [0.34, 0.66], Z = 4.26, $p < 0.0001$, 98% agreement rate) for pair one, and 0.30 (95% CI [0.11, 0.50], Z = 2.56, p = 0.0051, 97.5% agreement rate) for pair two, both indicating 'moderate agreement' between the two raters of each pair, based on Landis and Koch (1977) classifications. A third referee was consulted to resolve non-agreements between authors. At the full-text screening stage, each pair screened five publications. Full agreement between both pairs of raters was achieved during the latter stage. A full-text review was performed by A1 on the remaining 358 papers leaving 67 for the final review. As per other qualitative meta-synthesis, reference lists within included studies were hand-checked for relevant articles (Timulak, 2009). An additional 10 papers were identified from references. One study identified by the screening review as omitted by A1 was included, resulting in a total sample of 78 studies.

3.3.6 Quality Appraisal

We employed the NICE Quality appraisal checklist for qualitative studies to assess each study's quality (NICE, 2012). This tool includes a 14-measure checklist covering theoretical approach, study design, data collection, trustworthiness, analysis and ethics. The NICE appraisal tool employs a 3-level global scoring system ranging from '0', meaning few checklist criteria are met, and study conclusions are unreliable, to a score of '++' indicating

all/most of the checklist criteria are met and conclusions are reliable. Within the selected publications, 54 papers were rated ++, 24 papers were rated +, and no study scored 0. Of the papers reviewed, 20% were second reviewed by A2 to verify this scoring with 100% agreement. Papers generally scored a lower rating because they gave little insight into how the role of the researcher influenced the work or did not adequately describe the context and setting for data collection. These gaps are often because qualitative work is published in journals designed for quantitative work and word counts restrict the amount of methodological information qualitative researchers can share (Lachal et al., 2015; Levitt, 2018). Like other studies, lower quality papers contributed less to our analysis (Lachal et al., 2015). Of the 1,333 codes generated for this review, 83% came from papers rated ++ and 17% from papers rated +. See Appendix 3.2 for an example of the 'Quality Appraisal Tool'.

3.3.7 Data Extraction

There are various ways of conducting a qualitative meta-synthesis and our systematic review employs Thomas and Harden's Thematic Synthesis method (2008). Like Levitt (2018) "we wanted the analysis to be anchored in the original data, but use this as a means to establish wider theoretical conceptualizations" (p. 372). The authors employed an inductive approach to the analysis, which involved interpreting patterns and themes from within the data without being guided by a pre-existing theoretical framework. Instead, we used the contents of the studies as the basis for exploring potential relationships and patterns within the texts (Thomas & Harden, 2008). When conducting a qualitative meta-synthesis, authors must decide what text from primary studies constitutes data for their review (Finfgeld, 2003; Timulak, 2009). To gain as much insight as possible, our data extraction included data from the findings, discussion and conclusions of each primary study, including both participant quotes and the authors' interpretations (Lachal et al., 2015). Two papers included participants under 18, but only findings attributed to all participants, or quotes attributed to men over 18, were included. Similarly, in studies where participants' gender was mixed, only findings relating specifically to men, male attributed quotes, or findings relating to all project participants were reviewed. Data for this analysis was reviewed for anything that pertained to a risk or recovery factor as perceived or understood by participants or author/s. Risk factors were experiences identified in primary studies as potentially contributing to suicidal thoughts, feelings and behaviours. Recovery factors were experiences identified in primary studies as potentially helping men live with thoughts and feelings of suicide. It is important to flag that the qualitative nature of

our data means the risk and recovery factors in this review do not imply a causal relationship (Van Orden et al., 2010). We operationalize the terms 'risk factor' and 'recovery factor' to refer to themes that were deemed sufficiently common across studies as to indicate a potential association between that theme and suicide risk/recovery. This is an interpretative perspective and cannot be read as causal.

A qualitative meta-synthesis is iterative and as the coding developed there was enough variety in risk factor descriptions to further categorize them into 'distal' and 'proximal'. Distal factors were those associated with a potential underlying vulnerability to suicidal behaviours, for example: "Men were described as feeling like a failure because of financial burdens" (p. 719, Hagaman et al., 2018). Here the authors describe men who experience economic issues as feeling like a failure. We theoretically coded this as an example of a distal suicide risk in relation to potential feelings of failure and negative self-aversion. Proximal factors were those identified by participants and authors as associated with a suicide attempt or death (Turecki et al., 2019). For example: "I tried to set up a business for myself and my family and it didn't work. I lost money and there was no other alternative except killing myself" (p. 5, Ribeiro et al., 2016). Here, the participant draws a perceived association between his business failing and his suicide attempt. This association will be mediated by other potential risk factors, i.e., shame, debt, financial burden, and lack of security. We therefore do not claim that these are direct, causal risk factors, only that there was evidence to suggest a perceived association in the understandings of men who are suicidal or their bereaved loved ones that these factors were proximal to a suicide attempt or death. We acknowledge the limited and imperfect nature of these categorizations. However, in response to calls from suicidologists for research to delineate suicidal ideation from attempts, we wanted to provide colleagues with as much insight as possible from our data (Bloch-Elkouby et al., 2020; Glenn et al., 2017; Klonsky & May, 2015; Nock et al., 2010). Future research using appropriate methodologies can explore the causal relevance of our findings.

As there were remarkable consistencies between the accounts of men who are suicidal and people bereaved by male suicide, we did not separate out their coding. Indeed, combining these two different populations provided a useful source of triangulation with the coding from each population supporting findings in the other. For example, under the theme: "Suicide Associated With Proximal Killing of a Failed Self", a code from a bereaved wife was: "In the four weeks leading up to the suicide he […] felt like a failure" (p. 319, Kiamanesh et al.,

2015). The sentiment expressed here was thematically similar to that described by this example from a man who attempted suicide: “I feel like I failed, that’s why I did that [attempted suicide]” (p. 161, Cleary, 2012).

To help us understand how widespread a theme was, we quantified the number of codes and papers that constituted each thematic finding. This helped enhance data transparency and evidence our interpretations (Monrouxe & Rees, 2020). However, it is important to be cautious in terms of interpreting these numbers. Not all participants were asked the same questions; therefore, these numbers are not a true representation of actual prevalence (Levitt et al., 2016; Malterud, 2001; Monrouxe et al., 2020). It is also essential to consider that other research teams may have privileged other themes and understandings, resulting in different quantifications (Levitt et al., 2016). A qualitative meta-synthesis does not aim to quantify findings but to interpret them (Monrouxe et al., 2020). However, applying a degree of quantification helped anchor our findings in a metric to understand how commonly expressed a theme was across papers and by which demographic groups.

3.3.8 Data Analysis

The data analysis happened in the following steps. First, a data extraction sheet was completed by A1 for each study with a line-by-line coding of each primary paper for perceived risk and recovery factors (see Appendix 3.3 for an example of the ‘Data Extraction Tool’). Codes could range from a few words to several lines of text. Codes were then compared and organized into broader categories known as descriptive themes. These themes were descriptive because they reflect the content of the data without too much interpretation or analysis. Descriptive themes were then analysed to generate analytical themes that offer a deeper understanding of the data. This step is complex to document as it is the most interpretative aspect of the analysis when authors go beyond the verbatim content of primary studies to synthesize new explanatory frameworks (Attride-Stirling, 2001; Erwin et al., 2011, Lachal et al., 2017; Thomas & Harden, 2008; Xu, 2008). For example:

> *Basic Code:* Everything felt like a façade, like, if I was out—having fun, I was putting on a smile for the show of others. (p. 896, Oliffe et al., 2017)
> *Descriptive Theme:* Performance of Self to Conceal Distress
> *Analytical Theme:* Failing to Meet Norms of Male Success

Here we have taken the basic code of a man who concealed his distress from those around him by pretending he was "having fun" and placed it within a descriptive theme of "Performance of Self…" that provides a relative summary of the data. We then took an interpretive, analytical step to place this descriptive theme within a bigger explanatory framework that considered how men in our data felt a pressure to conceal their distress and perform wellness to the world in order to meet masculine norms of male success, and that fear of failing to do so ultimately seemed to drive an element of suicidal despair. While this last step is interpretative it is also rooted in evidence found in the data. To maintain reliability, regular consensus meetings were held between A1, A4 and A5 to discuss the evolving thematic framework (Lachal et al., 2017). To confirm the logic and validity of the analysis, 20% of papers were randomly selected and reviewed by A2 who developed an independent thematic framework. Following a consensus meeting with A4 and A5 it was considered that the framework developed by A2 was representative of the existing one developed by A1, though some wording of course differed. For example, A2 suggested a descriptive theme: "Suicide as a release from pain > seeking respite" whereas in our coding this descriptive theme was absorbed within the descriptive theme of "Suicide Associated With Proximal Intolerable Psychological Pain." Consensus was the ethos of this review with authors working to build a shared understanding of thematic interpretations rather than compete (Levitt et al., 2016). Throughout the review, any disagreements or uncertainties about themes were resolved by returning to the primary paper data and re-reading and reflecting on the texts to consider whether the evidence supported assertions.

The data analysis process is an iterative and evolving process involving a constant dialogue between the reviewer's thematic framework and the data of the primary studies (Dawson, 2019). Like other reviews, our thematic framework was continually revised as new data and reflections occurred (Paterson, 2012; Timulak, 2009). Careful and repeated readings of the studies, multiple feedback, including invaluable insights from anonymous peer reviewers and the editor, led to deeper reflections, and the emergence of a more refined framework. Trying to organize psychological phenomena into a neat and orderly thematic framework is challenging. The lack of hard boundaries around psychological phenomena means many thematic constructs were interrelated and interacted (Laubschler, 2003). Thematic framing entails a degree of compromise in trying to separate and conceptualize phenomena to aid colleagues' understandings and emphasize the importance of individual constructs but not

diminish the importance of their interaction. We have tried to address this by reviewing psychological phenomena individually in the results but discussing their critical interaction in the discussion.

Once a final thematic framework was arrived upon, a final consensus meeting was held with A1, A4, A5 and A6 to review and confirm the final thematic framing resulting in 1,333 basic codes nested within 24 descriptive themes and four analytical themes, split out into risk and recovery factors. There was full agreement with the final findings and this triangulation of authors and reviewers throughout the analysis gave insights a level of rigor (Lachal et al., 2015). All themes and codes were recorded in a document in Microsoft Excel (see Appendix 3.4 for a sample of the 'Codebook' and Appendix 3.5 for 'Coding Hierarchy').

3.4 Results

3.4.1 Characteristics of Studies

Not every paper recorded the number of participants but based on those that did this review covers a sample of at least 1,695 people - 902 men who were suicidal and 793 people bereaved by suicide. Studies were made up of interviews (n = 68), interviews and photo-voice (n = 6), interviews and focus groups (n = 2), mixed-methods (n = 1), and focus groups (n = 1). Study populations varied but were predominately men and women who had attempted suicide (n = 20), men who have attempted suicide (n = 18), people bereaved by male suicide (n = 18), people bereaved by suicide (n = 10) and men who have attempted suicide and/or have suicidal ideation (n = 5). Some studies focused on particular demographics: men under 40 (n = 15), elderly (n = 8), sexual minorities (n = 6), prisoners (n = 4), immigrants (n = 4), rural communities (n = 2), men with substance abuse challenges (n = 2), friends bereaved by male suicide (n = 2), sexual abuse survivors (n = 1), veterans (n = 1), parents bereaved by male suicide (n = 1), children bereaved by a fathers' suicide (n = 1) young men with psychosis (n = 1). Only 22% of papers provided a breakdown of participants' ethnicity and of these studies approximately 82% of participants were white. A major limitation of the literature is the lack of insight it can provide for the unique challenges and needs men from different racial demographics may have. Publishing dates were between 2000-2010 (n = 17) and between 2011-2020 (n = 61).

Location of studies included: Norway (*n* = 16), UK (*n* = 16), Canada (*n* = 11), Australia (*n* = 6), Brazil (*n* = 5), Ghana (*n* = 4), Ireland (*n* = 3), Sweden (*n* = 3), United States (*n* = 2), Italy (*n* = 2), South Africa (*n* = 2), Uganda (*n* = 2), Belgium (*n* = 1), Iceland (*n* = 1), Nepal (*n* = 1), Poland (*n* = 1), New Zealand (*n* = 1) and Taiwan (*n* = 1). This constituted two studies from lower-income countries (2%), twelve from middle-income (9%) and 64 from upper-income countries (82%). Income classifications were based on World Bank distinctions (World Bank, 2021). The skew towards upper-income contexts is not surprising as 75% of suicide research occurs in the USA, EU, Canada and Australia (Astraud et al., 2020). Primary studies were originally analysed using a range of methods, though the most common were Thematic Analysis (*n* = 25), Interpretative Phenomenological Analysis (*n* = 17) and Grounded Theory (*n* = 10). From the total sample, 15 papers were secondary analyses, and based on the rationale of other syntheses, we only included secondary studies when they provided valuable insights not covered in the primary work (Xu, 2008). Appendix 3.6 'Key Findings from Papers' provides a summary of each paper including aims, sample populations and key findings pertaining to the research question of this review.

3.4.2 Presentation of Results

Results are split into 1) risk factors; and 2) recovery factors. We have developed two models to represent thematic findings for each of these domains - see Figure 3.2 for '3 'D' Model of Masculine Norms and Male Suicide Risk' (3 'D' Risk) and Figure 3.3 for '3'R' Model of Male Suicide Recovery' (3 'R' Recovery). Both models are built on the reciprocal interaction between men's emotions, self-concept, interpersonal connections and psychological pain. Our 3 'R' Risk model suggests an aspect of men's psychological pain and suicide risk may be underpinned by denial, disconnection and dysregulation in the domains of emotions, self and interpersonal connections resulting from how masculine norms may shape some men's relationships with these phenomena. Our 3'D' Recovery model suggests that helping men to recognize, reconnect with and regulate these phenomena may help reduce their psychological pain and suicide risk. Central to the 3 'D' Risk model is the emergence of unbearable, dysregulated psychological pain and the potential activation of proximal risk indicators separate to distal factors. We speculate, in keeping with other theories of suicide, that at a certain point a threshold for tolerating psychological pain is breached and bereft of viable solutions to the pain, proximal drivers of suicide and suicidal behaviours are activated (Rudd,

2006). A potentially illuminating part of our model is the mirroring of risk factors in the distal and proximal domains. In our data, it appeared that proximal risk factors were a heightened manifestation of distal ones. The phenomena in our model are not fixed and stable. Emotions, self-concepts, interpersonal connections, and psychological pain are constantly in flux. Therefore, our model is temporally dynamic (Bryan & Rudd, 2016; Rudd, 2006). The constant and complex interaction of these factors may move men who are suicidal closer or further away from the proximal threshold of suicidal action.

Figure 3.2 *3 'D' Model of Masculine Norms and Male Suicide Risk*

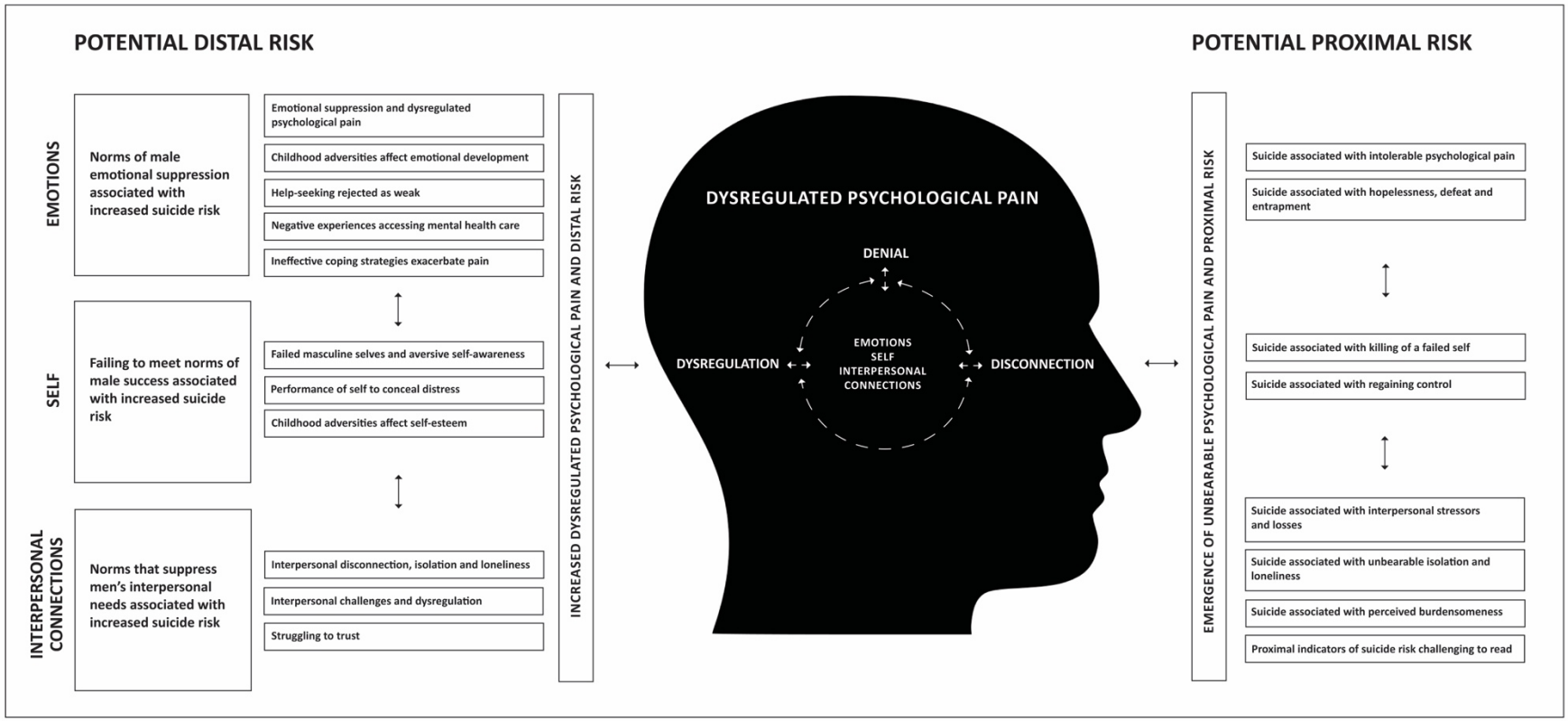
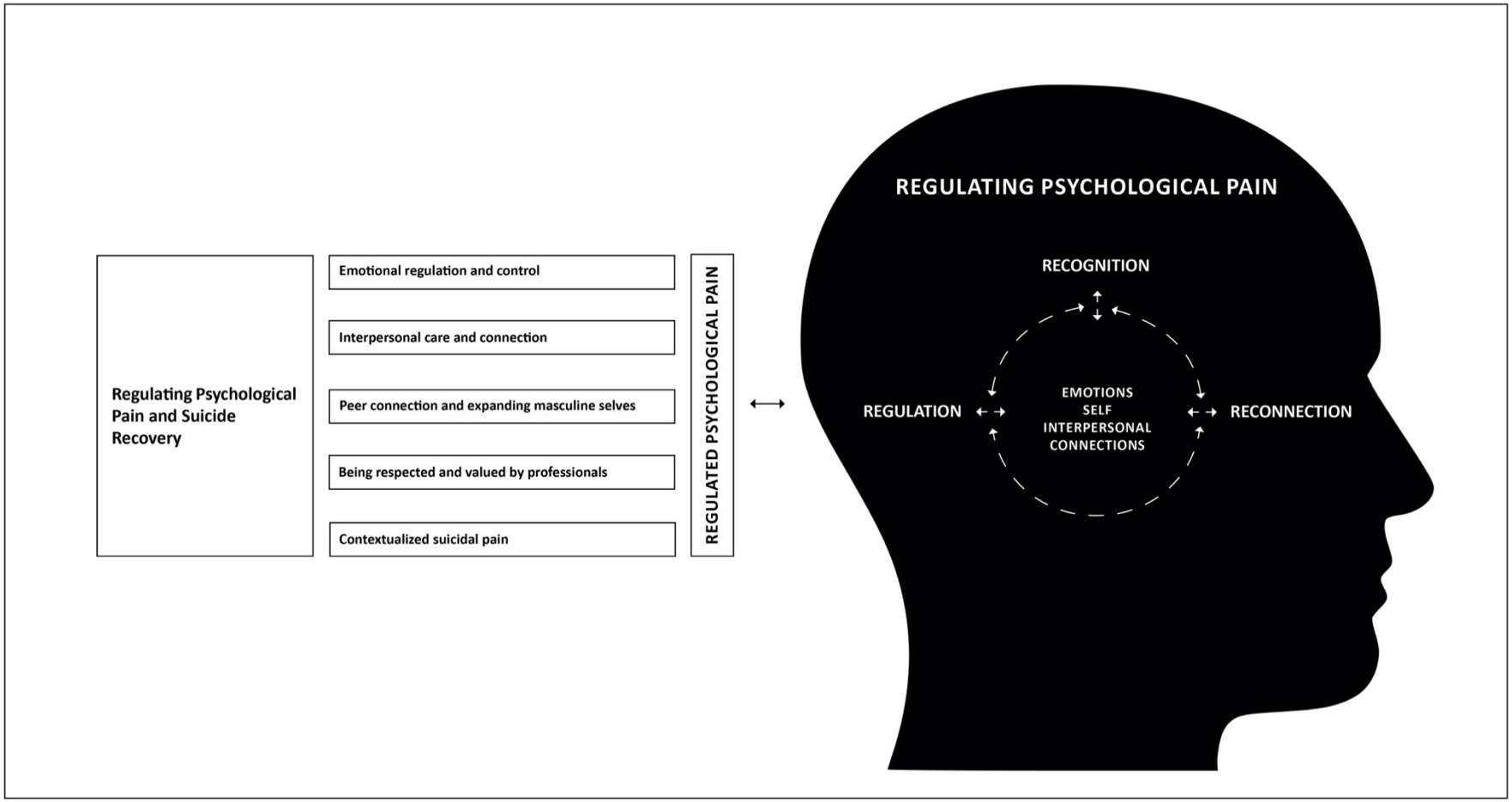


Figure 3.3 *3 'R' Model of Male Suicide Recovery*



In Table 3.1, 'Thematic Overview and Supporting Evidence,' we provide a full breakdown of our thematic framework, including the percentage of papers in support of each theme, their World Bank income classification, and NICE quality rating. We have also self-selected the richest quotes from study participants and authors to illustrate the credibility and commonality of our thematic findings, triangulating insight from both sources. In the text, we provide up to three references in support of salient points, but a full list of studies in support of each of these points can be reviewed in Appendix 3.7 'Supporting Evidence Index.'

Table 3.1 *Thematic Overview and Supporting Evidence*

Risk/ Recovery	Analytical Theme	Descriptive Theme	Papers (%)	Income* U/M/L (%)	NICE Rating** ++/+ (%)	Supporting Evidence
Risk	Norms of Emotional Suppression	n/a	92	83/14/3	72/28	**Study Participants:** "We are men, we are not supposed to talk about this and we are not allowed to express ourselves about emotions – this is the cost of manhood [...] we just block our feelings and then something comes up that pushes these points within us and then we actually have no resources in order to cope with these feelings or even face how we feel." (71, Iceland, Abuse Survivor, p. 1001) **Study Authors:** "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." (13, Ireland, Young Men, p. 504)
Risk	Norms of Emotional Suppression	Emotional Suppression and Dysregulated Psychological Pain	44	82/18/0	76/24	**Study Participants:** "If you keep holding things in [emotions] it's just going to get worse and worse and then it escalates and you want to do something, you just can't handle it anymore." (12, Ireland, Young Men, p. 160). **Study Authors:** "Thus, common to all the deceased, from whoever's perspective one examines it, was a lack of capacity to handle emotional distress or chaos, and a tendency to act upon oneself." (58, Norway, Young Men, Author, p. 229)
Risk	Norms of Emotional Suppression	Childhood Adversities Affect Emotional Development	46	92/8/0	78/22	**Study Participants:** ". . . many bad things happened in his childhood that he has never dealt with . . . and that he has, all the time, pushed it aside and pushed it aside . . . he felt so lonely . . . very lonely with all these bad feelings . . ." (30, Norway, p. 392) **Study Authors:** "All narratives described serious adverse childhood experiences impacting their mental health, experienced as intrusive flashbacks. There is a sense of a serious negative, global impact on their lives, which led up to the suicide attempts." (24, UK, Clinical/Young Men, p. 1122)
Risk	Norms of Emotional Suppression	Help-seeking Rejected as Weak	29	96/4/0	96/4	**Study Participants:** "I had this idea that asking for help or telling somebody how you're feeling would be a sign of weakness. I had a real tough image back home. I was a body builder. I was over 200 pounds. I never lost a fight. So I couldn't talk to my friends because it was a sign of weakness." (18, Canada, Young Men, p. 380)

						Study Authors: "Almost all men reported that their masculine beliefs led to them isolating themselves when they were feeling down, for example, to avoid imposing on others. Failure to manage emotions, or live up to expectations of happiness or coping also often led to a sense of lost control or guilt, as well as anxiety about having these perceived weaknesses or failures revealed." (56, Australia, p.5)
Risk	Norms of Emotional Suppression	Negative Experiences Accessing Mental Health Care	35	96/4/0	85/15	**Study Participants:** "I don't believe in these, the power of prescription drugs to just heal, you know, mental, psychological trauma." (24, UK, Clinical/Young Men, p. 1125) **Study Authors:** "Men in this study overwhelmingly rejected services that framed emotional distress and suicidal behavior as mental illness." (62, Australia, p. 153)
Risk	Norms of Emotional Suppression	Ineffective Coping Strategies Exacerbate Pain	42	82/15/3	85/15	**Study Participants:** "I was suffering and I started to need alcohol more and more – I was drinking to find a solution but when I drank I would think more about suicide . . ." (25, Italy, p. 513) **Study Authors:** "Many men stated that their attempts to manage problems to avoid revealing weakness or stigmatising labels, led them to isolate themselves and instead rely on coping strategies that required less immediate effort and provided short-term alleviation of problems, for example, drug or alcohol use, gambling, and working excessively. However, these strategies repeatedly made problems worse in the long term through, for example, debt creation, and emotional reaction and interpersonal conflicts." (56, Australia, p.5)
Risk	Norms of Emotional Suppression	Suicide Associated With Intolerable Psychological Pain	56	84/14/2	77/23	**Study Participants:** "I feel great pain and don't think about what I'm doing. I just want to end the pain." (10, Brazil, p. 1661) **Study Authors:** "In their suicide notes, many of the deceased described their self to be in a place of unbearable pain; they couldn't take it any longer or they couldn't live like this any more." (58, Norway, Young Men, p. 230)
Risk	Norms of Emotional Suppression	Suicide Associated With Hopelessness, Defeat and Entrapment	31	79/17/4	83/17	**Study Participants:** "The way I see it is that if you are going to live, you must have something to live for or at least something to look forward to, and that I have never had and will never get. So I see no reason why I should stay here then." (37, Norway, p. 5) **Study Author** "…suicidal behavior can be seen as a reaction or a response to a situation that involves defeat, rejection, or humiliation, in which there is no escape and no possibility of rescue. All of these characteristics were found in this study of men's suicide in postconflict Northern Uganda." (34, Uganda, p. 709)

Risk	Failing to Meet Norms of Male Success	n/a	76	81/15/3	75/25	**Study Participants:** "If men don't have a way to make it in the world, they don't exist, they're nothing, they don't matter. And so if you don't matter, it doesn't matter whether you're here or not." (45, Canada, p. 893) **Study Authors:** "Dan's suicide note conveyed a sense of profound personal failure; a feeling that he had let everyone down and a belief that he had failed to meet the expectations of the people who mattered most." (4, UK, Young Men, p. 262)
Risk	Failing to Meet Norms of Male Success	Failed Masculine Selves and Aversive Self-Awareness	54	76/19/5	71/29	**Study Participants:** "It just seemed like a lifetime of failure, like no sort of, you know, jumping from job to job. . . . I also, ehm, have a son from another relationship that I've never seen as well. It just seems, looking back on my adult life, it just stemmed from like one failure to another." (29, UK, Young Men, p. 1213) **Study Authors:** "Qualities held up as forms of capital or value for men, and men's lack of resources for securing those markers, served to marginalize and subordinate them within masculine hierarchies." (45, Canada, p. 894)
Risk	Failing to Meet Norms of Male Success	Performance of Self to Conceal Distress	31	100/0/0	88/12	**Study Participants:** "Everything felt like a façade, like, if I was out—having fun, I was putting on a smile for the show of others." (45, Canada, Participant, p. 896) **Study Authors:** "Farmers believed they should be strong in the face of adversity. They "put on a mask," thinking they should be able to deal with or manage the problem, or they avoided and isolated, pretending that everything was all right." (38, Australia, Farmers, p. 259)
Risk	Failing to Meet Norms of Male Success	Childhood Adversities Affect Self-Esteem	15	92/8/0	83/17	**Study Participants:** "He was, you know, quite a bright enough lad but he just had real problems with um reading and writing and stuff because of his dyslexia. It was quite severe and he had very low self-confidence, no self-worth, not enough support from the right kind of people." (53, UK, Bereaved, Young Men, p.245) **Study Authors:** "Central to Malik and Wes, and many other participants, were injuries that had occurred early on but carried significant weight into adulthood, fundamentally shaping their sense of self and self-worth." (45, Canada, p. 892)
Risk	Failing to Meet Norms of Male Success	Suicide Associated With Killing of a Failed Self	46	75/19/6	81/19	**Study Participants:** "I feel like I failed, that's why I did that [attempted suicide]." (13, Ireland, Young Men, p.501) **Study Authors:** "Loss of faith in themselves describes a general feeling of inadequacy or sense of failure in life as a central reason for the suicide attempt." (1, Ghana, p. 240)

Risk	Failing to Meet Norms of Male Success	Suicide Associated With Regaining Control	14	82/18/0	73/27	**Study Participants:** "Johan said that he was motivated to attempt suicide to hide his failures and appear in control: 'No one has to know that I actually basically failed this year. No one has to ever find out. You know, it would be my little secret.'" (43, South Africa, Young Men, p. 790) **Study Authors:** "Thus, worthless on their own, unable to act differently to regulate emotions and thereby be able to comfort themselves, the suicidal act seems to have been a desperate operation by a failing self to restore itself." (58, Norway, Young Men, p. 231)
Risk	Norms that Suppress Men's Interpersonal Needs	n/a	82	83/16/2	72/28	**Study Participants:** "You look at everybody as the enemy before you look at them as a friend." (69, Canada, Clinical, Participant, p. 35) **Study Authors:** "Participants detailed failed relationships as triggering their suicidality." (45, Canada, p. 896)
Risk	Norms that Suppress Men's Interpersonal Needs	Interpersonal Disconnection, Isolation and Loneliness	46	83/14/3	69/31	**Study Participants:** "He was a man that would always keep things to himself ... I tried to get things out of him ... but he just couldn't discuss it." (51, UK, p. 506) **Study Authors:** "Being isolated ultimately heightened participants risk for suicide." (45, Canada, p. 895)
Risk	Norms that Suppress Men's Interpersonal Needs	Interpersonal Challenges and Dysregulation	28	82/18/0	73/27	**Study Participants:** ''Life with my wife on an everyday basis was hard, I felt I wasn't capable of loving her ... and it was difficult with the child. I didn't have many positive feelings and I was very passive." (6, Norway, Substance Abuse, Young Men, p. 251) **Study Authors:** "All participants reported struggling to form and maintain romantic relationships." (43, South Africa, Young Men, p. 788)
Risk	Norms that Suppress Men's Interpersonal Needs	Struggling to Trust	14	100/0/0	73/27	**Study Participants:** "I never trust anybody really because I'm not wonderfully able to take the slap in the face. I do be always waiting for the slap in the face - rejection. And that's why I always keep up the barrier so that I'm ready for it. If it comes, I'm ready for it." (12, Ireland, Young Men. p. 172) **Study Authors:** "Implicit in their remarks was a lack of trust in themselves and others, resulting in difficulties in reaching out for support in times of distress for fear of rejection and criticism." (11, America, Immigrants, p. 359)
Risk	Norms that Suppress Men's	Suicide Associated With Interpersonal	42	82/18/0	73/27	**Study Participants:** "He was always talking about death. He said he would die because the wife had left him." (3, Ghana, p. 661) **Study Authors:**

	Interpersonal Needs	Stressors and Losses				"Three quarters of our participants described relationship problems as the main reason or trigger for their suicidal act." (37, Norway, p. 6)
Risk	Norms that Suppress Men's Interpersonal Needs	Suicide Associated With Unbearable Isolation and Loneliness	23	72/28/0	83/17	**Study Participants:** "Umm, because of my feelings of loneliness, I – I felt that life – don't know, life was just very difficult... and so I thought of various ways of committing suicide." (24, UK, Clinical/Young Men, Participant, p. 1123) **Study Authors:** "Social isolation and not belonging were keys to most men's suicidality." (21, Canada, Sexual Minority, p. 1538)
Risk	Norms that Suppress Men's Interpersonal Needs	Suicide Associated With Perceived Burdensomeness	8	50/50/0	67/33	**Study Participants:** "The only thing that spoke against suicide was that I'd hurt my family. The things that spoke for suicide were so many more, for instance then that my family would be better off without me, since my influence on their lives was negative." (54, Sweden, p.5) **Study Authors:** "many of our findings suggest that male narratives, more often than female, supported the idea that an act of suicide was in some aspect an effort to fulfill obligations or ease burdens on family members." (27, Nepal, p.723)
Risk	Norms that Suppress Men's Interpersonal Needs	Proximal Indicators of Suicide Risk Challenging to Read	19	93/7/0	93/7	**Study Participants:** "I know towards the end he was saying I can't remember whether he said it when he was sober or just when he was drunk - that he was going to kill himself (...) But you know, if I had a fiver for every time I've said it, I'd be a bloody rich man. So I probably didn't take much notice of it." (50, UK, Bereaved, p.425) **Study Authors:** "The deceased were perceived as very successful by those around them, and thus were interpreted as being protected against suicide." (30, Norway, p. 396)
Recovery	Regulating Psychological Pain		78	84/15/2	74/26	**Study Participants:** "Once you do get into something like CBT, Buddhism or whatever, finding a way through the talking therapies, through your issues, is remarkably successful. As soon as we abandon our obsession of feeding people with chemicals... that's been an appalling waste of time in my life." (41, UK, Probation Clients, p. 150) **Study Authors:** "Participants said that communicating their emotional distress and seeking help from others were central strategies to protect themselves against becoming suicidal again." (43, South Africa, Young Men, p. 792)
Recovery	Regulating Psychological Pain	Emotional Regulation and Control	47	89/8/3	86/14	**Study Participants:** "If I talk about it sometimes then it's a bit better instead of bottling it all up." (64, UK, Prison, p. 319) **Study Authors:**

						"Disclosure was a huge step for all the participants, whether it was with a partner, friend, expert, counsellor or others. When they finally disclosed what had happened, they experienced great positive energy and a new sense of freedom." (71, Iceland, Abuse Survivors, p. 1001)
Recovery	Regulating Psychological Pain	Interpersonal Care and Connection	32	80/16/4	72/28	**Study Participants:** "she sees my wrist (…) she just hugged me, she cried and she cried, and I just balled and balled, and she told me she loved me regardless . . . and she saved my life, knowing that someone loved me regardless." (19, New Zealand, Sexual Minority, Young Men, p.12) **Study Authors:** "Their suicidal crisis appeared to provide them with an opportunity to reconnect with people close to them and find existential meaning in relationships." (43, South Africa, Young Men, p. 790)
Recovery	Regulating Psychological Pain	Peer Connection and Expansive Masculine Selves	24	84/16/0	74/26	**Study Participants:** "I was very well received by my male buddies who had been through the same and it was just great to be able to do this [disclosure] at this time because it's a great positive energy that gushes forth following disclosure. Then there was always the hope that I would survive like those who had been through the same and they survived!" (71, Iceland, Abuse Survivors, p. 1001) **Study Authors:** "Participants stressed the therapeutic value of being able to mix with people who had survived similar circumstances; this helped them to appreciate they were "not the only ones like this." Moreover, they were able to verbalize how they were feeling in a forum in which they were not afraid of being labeled as crazy or weird. Such contact and interaction served to normalize suicide, normalize their difficulties and, ultimately, normalize them as human beings." (29, UK, Young Men, p.1212)
Recovery	Regulating Psychological Pain	Being Respected and Valued by Professionals	19	100/0/0	87/13	**Study Participants:** "She wasn't ... yes, 'pitying' again then. We were two people talking together on equal terms, not prisoner and jailer. She was simply so fantastic ... and it was as if I could talk with her without feeling that, – what shall I say – she would not divert the conversation, no matter what." (74, Norway, p. 170) **Study Authors:** "On this occasion, he had taken a medication overdose and tried to shoot himself. Lara avoided a mental illness framing of David's difficulties, instead exploring the underlying social and personal issues he raised. David described Lara as "respectful." (62, Australia, p. 155)
Recovery	Regulating Psychological Pain	Contextualized Suicidal Pain	31	71/25/4	79/21	**Study Participants:** "I had a psychiatrist, kind of like an old man and this guy all he would do was put me on medication. He wouldn't help me. He wouldn't talk to me." (69, Canada, Clinical, Participant, p. 36)

	Study Authors: "Future action plans for the prevention of suicide should include a broader perspective of suicide than the illness model." (59, Norway, p. 8)

3.4.3 Cultural Norms of Masculinity and Male Suicide Risk

An association between certain cultural norms of masculinity and potential male suicide risk factors was the biggest finding of this review, evidenced in 96% papers and generating 1,070 codes. These findings are categorized into three analytical and 19 descriptive themes (see Table 3.1 for Thematic Overview). Across different cultural contexts including displaced person camps in Uganda (Kizza et al., 2012), rural farming communities in Australia (Kunde et al., 2018) and urban inner-cities in Brazil (Meneghel et al., 2012) there appeared to be prevailing norms and expectations for male behaviour. Reported norms included male strength, self-reliance, stoicism, emotional restrain and suppression; men as providers, protectors, battlers, financially and romantically successful, independent and virile (Andoh-Arthur et al., 2018; Kunde et al., 2018; Meneghel et al., 2012).

These perceived norms appeared to be modelled culturally as well as environmentally by family, friends, peers and institutions, and were described as creating certain expectations for male behaviour that seemed to limit the scope of male 'being', narrowing possibilities for existence, as exemplified by the following quote from a 23-year old gay man in South Africa who had attempted suicide: “I come from a home where you have your gender roles, men don’t cry and my dad didn’t show that he is sad, my brothers as well. You can see it in them, so obviously I adopted those ways of doing things” (p. 789, Meissner & Bantjes, 2017).

In this review, specific masculine norms relating to male emotional suppression, failing to meet standards of male success and the devaluing of men’s interpersonal needs appeared to be associated with some men experiencing denial, disconnection, and dysregulation within three core psychological domains: 1) emotions, 2) self, and 3) interpersonal connections. These processes appeared to be associated with 1) increasing men's psychological pain, and 2) diminishing men's ability to regulate that pain, which we suggest elevates suicide risk. Our findings explore potential suicide risk in the domains of emotions, self and interpersonal connections individually. This is to provide the reader with context for specific manifestations of harm. However, in the discussion, and as represented in the 3 ‘D’ Risk model, we speculate that it is the interaction and accumulation of psychological pain across these three domains that may be critical to elevating suicide risk and distinguishing men who are suicidal from other men similarly socialized in masculine norms but not suicidal.

3.4.3.1 Norms of Male Emotional Suppression

In our review we found evidence in 92% of papers to suggest norms of male emotional suppression were associated with increased psychological pain and suicide risk in men. This analytical theme comprises the following 8 descriptive themes.

3.4.3.1.1 Emotional Suppression and Dysregulated Psychological Pain

Norms around male emotionality - stoicism, suppression, and the need for men to be independent, strong and cope with problems - were a perceived distal risk factor in 44% of papers. The cultural denial of the fullness of men's emotionality appeared to wreak havoc on men's well-being as depicted in this quote from a 60-year-old gay man in a Canadian study with men who were suicidal: “Conditioning us [men] away from our emotional reality is going to make it harder when your emotional reality is what’s ripping you apart” (p. 892, Oliffe et al., 2017).

Norms of male emotional suppression appeared to impact upon some men’s *internal* relationship with their emotional experience by seeming to undermine their ability to understand, process and manage their emotions and psychological distress (Akotia et al., 2019; Cleary, 2005; Kunde et al., 2018). Participants, young and old, described, or were described as, lacking the language and cognitive tools to recognize and regulate their own distress despite mounting psychological pain. A young man from a study in Ireland that interviewed men within 24 hours of a suicide attempt remarked: “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.” (p. 501, Cleary, 2011). Men described living in a state of denial (Kiamanesh et al., 2015; River, 2018; Tryggvadottir et al., 2019), or of being aware of their distress but ignoring their feelings because they did not know how to deal with them (Cleary 2012; Meissner & Bantjes, 2017; Rasmussen et al., 2018).

Norms of male emotional suppression also appeared to impact some men’s *external* expression of emotion. Cultural expectations for men to be independent, strong, and cope seemed to affect some men’s way of inter-relating as they described concealing their emotional reality from others (Cleary, 2005; Kunde et al., 2018; Oliffe et al., 2018) as illustrated by this quote from a 36-year-old man in Australia who had attempted suicide:

> "With my closest friends it was, 'I don't want you to know how I feel'. I'm a dad of three kids and a husband. I've got a good job. I don't want you to know that I'm so sad that I cry at red lights" (p. 264, Fogarty et al., 2018).

Concealing their emotional reality appeared to serve different purposes. Some men described hiding their struggles because they did not want to burden or disappoint loved ones (Biong & Ravndal, 2007; Cleary, 2005; Everall et al., 2006). Some men felt their role as masculine protector meant they should protect significant others from their pain (Oliffe et al., 2017; Oliffe et al., 2018), while others described a lack of trust and psychological safety with which to share vulnerability with others (Cleary, 2005; Meissner & Bantjes, 2017). Other men described learning not to express their emotions for fear of showing weakness (Everall et al., 2006; Jordan et al., 2012; Rasmussen et al., 2018) or because they understood emotional suppression as representing masculine control (Meissner & Bantjes, 2017).

As challenges in life, and unprocessed distress in response to them, accumulated and built up internally, the impact of men's emotional denial and disconnection appeared to lead to a perceived dysregulation of emotions and psychological pain. Men's emotional interiors were described as chaotic, overwhelming, and exhausting to inhabit and within this dysregulated state, thoughts of suicide sometimes emerged (Benson et al., 2016; Cleary, 2012; Salway & Gesink, 2018). A 25-year-old Canadian man described his interior state in response to difficulties expressing emotions as such: "I felt like I was treading in a hurricane, you feel very tired, kind of exhausted and when you get a little break then something comes along and just washes you over and you're choking and drowning again" (p. 381, Everall et al., 2006).

3.4.3.1.2 Childhood Adversities Affect Emotional Development

In 46% of studies complex events in childhood and adolescence were associated with impacting upon men's emotional development. The nature of childhood challenges varied with specific references made to abuse (Biong & Ravndal, 2007; Chung et al., 2015; Tryggvadottir et al., 2019), neglect (Biong & Ravndal, 2007; Elliott-Groves, 2018; Kiamanesh et al., 2015), bereavement (Chung at al., 2015; Fogarty et al., 2018; Tzeng, 2001), abandonment (Biong & Ravndal, 2007), family break-up (Chung at al., 2015; Meissner & Bantjes, 2017; Oliffe et al., 2017), bullying (Cleary, 2005; Ferlatte et al., 2019; Kiamanesh et al., 2015), homophobia (Ferlatte et al., 2019; McAndrew & Warne, 2010; Salway & Gesink,

2018), drug use (Mackenzie et al., 2018; Rasmussen & Dieserud, 2018), violence and conflict (Cavalcante & Minayo, 2015; Elliott-Groves, 2018; Ferlatte et al., 2019), critical and demanding caregiver/s (Biong & Ravndal, 2007; Fogarty et al., 2018; Rasmussen & Dieserud, 2018), addicted caregiver/s (Elliott-Groves, 2018; Kiamanesh et al., 2015, McAndrew & Warne, 2010), and/or distant or absent caregiver/s (Gajwani et al., 2018; McAndrew & Warne, 2010; Meissner & Bantjes, 2017). Many participants described certain experiences in early-life as distressing, of unmet emotional needs (Kiamanesh et al., 2015; McAndrew & Warne, 2010; Rivlin et al., 2013) and of growing up with a sense that "the world is not a safe place" (p. 319, Oliffe et al., 2019). A family member of a young Norwegian man who died by suicide, commented on how childhood challenges with his father had impacted the deceased: “he shut it inside in a way ... he was so angry, but he was unable to just get it out properly” (p.337, Rasmussen et al., 2018). To manage their distress, some participants appeared to adopt different coping strategies, from emotional suppression to self-harm and substance abuse (Biong & Ravndal, 2009; Chung at al., 2015; Everall et al., 2006). For some participants, the intense distress of childhood experiences seemed to lead to an early cognitive association with death as a release from pain (Meissner & Bantjes, 2017; Rivers et al., 2018; Salway & Gesink, 2018). In relation to experiencing abuse as a child, a 71-year-old gay man from Canada remarked: “I would wish very much that I was dead, even at an age when I am not sure a kid understands what death is” (p. 1533, Ferlatte et al., 2019). Men in various studies suggested their suicidal behaviours might be linked to these challenging childhood experiences (Biong & Ravndal, 2007; Rivlin et al., 2013; Vatne & Naden, 2014).

3.4.3.1.3 Help-Seeking Rejected as Weak

In 29% of papers in upper- and middle-income contexts, we found evidence to suggest that cultural expectations for men to be strong and cope meant some participants (young and old) often perceived talking about their problems or seeking professional help as a ‘weakness’ and a loss of masculine control (Everall et al., 2006; Kiamanesh et al., 2015; Oliffe et al., 2017). A 21-year-old man from South Africa who had attempted suicide remarked: “You don’t feel comfortable sharing problems with people, because people might think you are weak or you are less of a man ... Guys don’t ask for help and that is the problem” (p. 788, Meissner & Bantjes, 2017). These attitudinal barriers also appeared to limit some significant others’ ability to persuade men to access professional help (Creighton et al., 2017; Kiamanesh et al.,

2015). This 57-year-old daughter in Australia whose father attempted suicide commented: “I know from my own personal experience with my dad, he won’t accept the help really. I could set up a hundred different things, to be honest, but he’ll say, no, I don’t need it...” (p. 265, Fogarty et al., 2018).

3.4.3.1.4 Negative Experiences Accessing Mental Health Care

In 35% of papers from upper-income studies, some men did seek help but described negative encounters with mental health services and professionals. Cultural norms appeared to impact male distress presentations and how these were read by service providers. When men concealed or denied their pain, doctors appeared to take them at face value. If men communicated their despair in matter-of-fact tones, they were perceived as lacking the necessary affect to indicate an imminent crisis (Kunde et al., 2018; Peters et al., 2013; Strike et al., 2006). Mental health systems were characterized by participants as under immense strain, time-poor and focused on short-term solutions such as medical prescriptions (Peters et al., 2013, Tryggvadottir et al., 2019; Vatne & Naden, 2014). A mental illness framing of suicidal behaviours and a lack of acknowledgement for underlying causes was described as a source of frustration for some men who felt professionals did not fully acknowledge the depths of, or contexts for, their despair (Ferlatte et al., 2019; Vatne & Naden, 2014; Wiklander et al., 2003). This participant from a study with men who were suicidal and had a clinical diagnosis in Canada, commented: “You cannot have a patient come in your office for 5 minutes and give him a diagnosis or send him on his way with medications. There’s more to getting well than medication” (p. 35, Strike et al., 2006).

Some men described an alienating lack of autonomy in treatment plans and of the need to trust health professionals with dismissive and stigmatizing staff seeming to put some men off from seeking support (Fogarty et al., 2018; River, 2018). Counselling was reported to be too expensive though the preferred intervention for some men (Ferlatte et al., 2019; Oliffe et al., 2019; Strike et al., 2006). Significant others also described challenges navigating mental health systems. A medical focus on emergency response only seemed to leave some families dangerously unsupported (Peters et al., 2013). A woman in Australia whose husband died by suicide commented:

> "How can somebody stab themselves one night, need 36 stitches, and say they want to be dead, and the next day they ring up and say, he's fine to go home now? So that—I just couldn't believe it. I stood on the phone, I said, "He's what?" "Oh, yes," he [hospital employee] said, "he's fine now"" (p. 313, Peters et al., 2013).

3.4.3.1.5 Ineffective Coping Strategies Exacerbate Pain

In 42% of papers, we found evidence to suggest that the effect of masculine norms such as emotional non-disclosure and coping with problems alone, appeared to lead men to find their own solutions and strategies to manage and regulate their distress. Participants irrespective of demographics or location described seeking respite from mounting despair through socially sanctioned 'male' behaviours (Creighton et al., 2017; Oliffe et al., 2019; Ribeiro et al., 2016) such as drinking (Cleary, 2005; Kunde et al., 2018; Meissner & Bantjes, 2017), drugs (Biong & Ravndal, 2007; Gajwani et al., Ribeiro et al., 2016) violence/aggression (Costa & de Souza, 2017; Everall et al., 2006; Meissner & Bantjes, 2017), gambling (Biong et al., 2007; Jordan et al., 2012; Kizza et al., 2012), and/or sex (Strike et al., 2006). References to self-harm cutting - more commonly associated with women - were also made (Everall et al., 2006; Meissner & Bantjes, 2017; Rivlin et al., 2013). These behaviours were described as 'pain-relief strategies' that were described as helping men to relax and release tension (Meissner & Bantjes, 2017; Rivlin et al., 2013), to cope and feel in control (Cleary, 2012; Owens et al., 2011; Rivlin et al., 2013), to numb/escape feelings (Biong & Ravndal, 2009; Kizza et al., 2012; Meissner & Bantjes, 2017), turn off thoughts (Biong & Ravndal, 2007; Kizza et al., 2012), self-medicate (Creighton et al., 2017; Mackenzie at al., 2018; Oliffe et al., 2019), and stimulate positive affect (Biong & Ravndal, 2009; Cleary, 2005). A participant from an Irish study with men who had attempted suicide recalled: "Denying, denying meself that, to meself, like I was depressed, you know? And I was using all sorts of drugs to, just kind of, to go out to enjoy meself basically (…)" (p. 163, Cleary, 2005).

Alcohol and drugs were also cited as helping men open up in a way they did not feel able to when sober (Biong & Ravndal, 2009; Cleary, 2005). For men who experienced adversity in childhood these pain-relief strategies could often start early in life (Gajwani et al,, 2018; Jordan et al, 2012; McAndrew et al., 2010). While these behaviours appeared to provide short-term relief, they were associated with failing to resolve underlying issues and potentially compounded long-term damage by seeming to increase some participants' shame

and self-condemnation (Hagaman et al., 2018; Mackenzie et al., 2018), interpersonal stress and conflict (Knizek & Hjelmeland, 2018; Player et al., 2015; Ribeiro et al., 2016) and isolation (Peters et al., 2013; Oliffe et al., 2019). A 35-year-old, UK man on probation for shoplifting who attempted suicide by cutting, remarked: "Although I'm trying to lift myself with this short term miracle [drinking], long term it was doing me more damage because it was pushing me lower and lower" (p.149, Mackenzie at al., 2018). Many men described becoming trapped in chaotic cycles of seeking relief from their psychological pain via behaviours that seemed to compound their pain and potentially leave them increasingly isolated from support and intervention. As their psychological pain intensified some men described escalating their substance use to harder drugs or becoming addicted (Biong & Ravndal, 2007; Cleary, 2012; Creighton et al., 2017).

3.4.3.1.6 Suicide Associated With Intolerable Psychological Pain

In this review, the most common proximal description of what drove suicide was as a release from unbearable psychological pain (Andoh-Arthur et al., 2018; Benson et al., 2016; Cavalcante & Minayo, 2015; Kizza et al., 2012). In 56% of papers, across cultural contexts, men, young and old, described being overwhelmed by a generalized and intolerable state of emotional and psychological pain. Lacking tools to regulate this distress, suicide was perceived as the only way to stop the pain (Cleary, 2012; Kiamanesh et al., 2015; Oliffe et al., 2017). An Italian man who had attempted suicide recalled: "Sometimes you try to cut yourself to let this pain out of your body, but you know it won't work . . . the only thing that works is suicide . . ." (p. 513, Ghio et al., 2011). A 60-year-old unemployed gay man from Canada also described his suicide as a pain-ending strategy: "Mostly the experience of that intense despair that I would feel suicidal is interior (…) The worst pain is, you just don't think it will ever stop" (p. 893, Oliffe et al., 2017)

3.4.3.1.7 Suicide Associated With Hopelessness, Defeat and Entrapment

Along with descriptions of a generalized state of psychological pain, in 31% of papers more specific proximal associations with feelings of hopelessness, defeat and entrapment as drivers of suicidal action were referenced. Some men described a poverty of internal resources with which to respond to the challenges consuming their lives. A perceived lack of autonomy, control and agency to redirect their lives and regulate their distress appeared to create a state of hopelessness, defeat and entrapment (Everall et al., 2006; Kjlseth et al., 2010; Rasmussen,

Dieserud et al., 2014). For some men, life was described as becoming devoid of meaning and purpose and they described acclimatizing to suicidal thoughts as a way out of a hopeless, defeated and entrapped situation (Andoh-Arthur et al., 2018; Cleary, 2012; Player et al., 2015). This quote from a 23-year-old Canadian man about his suicide attempt describes his feelings of entrapment: “Everything seemed very dark in a lot of ways. I had the feelings of being trapped, sometimes hopelessness, like I wasn’t ever going to get out of it” (p. 378, Everall et al., 2006). A young man who died by suicide in Norway described in his suicide note a sense of hopelessness and defeat: “I am sorry. There is so much I wanted to say, but this is how it is. ... I can’t find a path in this life” (p. 334, Rasmussen et al., 2018).

3.4.3.1.8 Summary

In 92% of papers we found evidence for a potential association between norms of male emotional suppression and increased psychological pain and suicide risk. Norms of male emotional suppression and expectations for men to cope, appeared to leave some men struggling to regulate their emotional responses to life’s challenges and vulnerable to accruing psychological pain with no meaningful release for that distress. The potential denial, disconnection, and dysregulation of some men’s emotions appeared to 1) increase some men’s psychological pain and 2) diminish their ability to regulate that pain effectively, potentially elevating suicide risk (see Figure 3.2). Emotional suppression was associated with denial and disconnection in terms of men's internal relationship with their emotions and ability to recognize their own distress, and/or their external expression of emotions and ability to communicate their distress to others. As challenges in life mounted and accumulated, men's emotional denial and disconnection was associated with a dysregulation of distress. For men who experienced challenges in childhood, this emotional dysregulation may be doubly compounded through the impact of early life exposure to psychological pain and then being socialized in masculine norms to suppress emotions. Norms of male emotionality seemed to impact help-seeking behaviours. Some men appeared to reject help-seeking as a sign of weakness. Other men sought help but described negative encounters where their distress was misread. Many men appeared to regulate their psychological pain through socially sanctioned male behaviours such as drinking that were described as providing short term respite but seemed to compound psychological pain over the long term. In a proximal context some men appeared to become trapped in dysregulated psychological

pain. Unbearable psychological pain and to a lesser extent feelings of hopelessness, defeat and entrapment were associated with potential proximal drivers of suicide.

3.4.3.2 Failing To Meet Norms of Male Success

In 76% of papers we found evidence to suggest that failing to meet norms of male success was associated with increased psychological pain and suicide risk. This analytical theme comprises the following 5 descriptive themes.

3.4.3.2.1 Failed Masculine Selves and Aversive Self-Awareness

Across 54% of studies, evidence suggested that norms of male success were internalized and became a standard by which participants appeared to evaluate themselves and their social value. A repeated pattern emerged of some men seeming to harbour a socially "othered" or "failed" element/s of their masculine identity (Akotia et al., 2019; Jordan et al., 2012; Kunde et al., 2018). As this participant, aged between 50 and 59, from a Canadian study with suicidal men remarked:

> "Expectations I've had on myself in terms of what I consider to be successes in life—a good father, a good husband, a good provider, um, those are probably at the top of the list, and it's my belief I failed at—at all of those three responsibilities" (p. 324, Oliffe et al., 2019).

Perceived masculine failures varied, with specific references made to employment problems or not being able to financially provide (Andoh-Arthur et al., 2018; Chung at al., 2015; Ferlatte et al., 2019), mental health struggles (Creighton et al., 2017; Elliott-Groves, 2018; Strike et al., 2006), relationship problems/breakdowns (Bell et al., 2010; Kiamanesh et al., 2015; Meissner & Bantjes, 2017), sexual problems (Andoh-Arthur et al., 2018, Costa & de Souza, 2017; Kizza et al., 2012), sexuality (Ferlatte et al., 2019; McAndrew & Warne, 2010; Meissner & Bantjes, 2017), sexual abuse (Rivlin et al., 2013; Tryggvadottir et al., 2019), failing at studies (Bell et al., 2010; Stanley et al., 2009), gambling addictions (Jordan et al., 2012), criminal behaviour (Owens et al., 2011), and aging (Cavalcante & Minayo, 2015; Costa & de Souza, 2017; Meneghel et al., 2012). While we cannot draw direct cultural comparisons from our data, expectations for male behaviour showed some variety across cultures and demographics. In Ghana, and Uganda, masculine norms were described as

centring around financial provision and sexual prowess (Akotia et al., 2019; Kizza et al., 2012; Osafo et al., 2015). Poverty, migration, war and displacement were perceived as contributing to some men being unable to fulfil these roles. In rural Brazil, honour cultures appeared to dictate that men are the head of the family, and men who are suicidal described being ashamed when they could not work anymore (Meneghel et al., 2012). Similarly, older men in Brazil described being unable to deal with the loss of family authority as they aged and perceived themselves to become "useless" (Costa & de Souza, 2017; Gutierrez et al., 2015; Meneghel et al., 2012). Fear of failure appeared to loom large for young men in upper- and middle-income locations, especially in relation to exam pressures, relationship challenges or a mental health diagnosis (Bell et al., 2010; Cleary, 2005; Jordan et al., 2012). Gay and bisexual men described being impacted by both heterosexist stigma relating to their sexuality and general masculine norms for men to be strong, financially successful and emotionally restrained (Ferlatte et al., 2019; McAndrew & Warne, 2010, River, 2018).

Across different cultural contexts, and different demographics, a similar psychological pattern appeared to emerge, of men perceiving aspect/s of their selfhood as transgressing social and cultural expectations for what a successful and socially valuable man should be. The internalized stigma attached to perceived losses of masculine capital, appeared to erode the self-esteem of men who are suicidal and became a source of shame (Andoh-Arthur et al., 2018; Bell et al., 2010; Kiamanesh et al., 2015). Perceiving themselves to be a failure was described as emotionally painful for participants. As well as shame, failure was described as generating feelings of stress (Oliffe et al., 2019; Salway & Gesink, 2018), anger (Rasmussen et al., 2018), inadequacy (Kizza et al., 2012), incompetency (Biong & Ravndal, 2009; Kizza et al., 2012), anxiety (Bell et al., 2010), guilt (Rasmussen et al., 2018), self-loathing (Akotia et al., 2019; Biong & Ravndal, 2009; Chung at al., 2015), self-blame (Oliffe et al., 2019; Rasmussen et al., 2018) and self-condemnation (Kizza et al., 2012; McAndrew & Warne, 2010; Rasmussen et al., 2018). A 21-year-old from South Africa who had attempted suicide commented: “That feeling of a girl leaving you like that. It is a feeling of you don’t feel good enough, you don’t feel sufficient, or you are not man enough and suddenly once again you feel ashamed of yourself” (p. 788, Meissner & Bantjes, 2017).

3.4.3.2.2 Performance of Self to Conceal Distress

In 31% of papers from upper-income studies some men who are suicidal described disconnecting from their selfhoods by creating a 'false' self that they presented to the outside world - of someone well, happy and coping - to conceal their inner distress (Everall et al., 2006; Rasmussen et al., 2018; River, 2018). A UK father whose son died by suicide commented: “He’d present a façade to suggest that things were normal when in fact they weren’t” (p.3, Owens et al., 2011). Suppressing their authentic self to perform 'wellness' was described as effortful and appeared to consume some participants' cognitive and emotional resources. This performance of self was described as undermining some men’s sense of coherent self-identity, mental wellbeing, and ability to create authentic and meaningful social connections, potentially further undermining self-esteem and amplifying isolation and distress (Cleary, 2005; McAndrew & Warne, 2010; Rasmussen et al., 2018). A young man from Ireland who had attempted suicide remarked: “I hate myself for trying to be somebody else (…) I got so pissed off putting on a front - always putting a happy face on and always being a laugh, a joke” (p. 163, Cleary, 2005).

3.4.3.2.3 Childhood Adversities Affect Self-Esteem

In 15% of studies, challenges in childhood were described as affecting the development of some men’s self-esteem and self-worth. Men described feeling worthless, abnormal, inadequate, out of place or ashamed in their childhoods (Kiamanesh et al., 2014; Meissner & Bantjes, 2017). A gay man in a UK study described how the realisation of his sexuality at school impacted his sense of self: “A deep thing of dissatisfaction with myself... dislike of myself” (p. 96, McAndrew & Warne, 2010). The legacy of these challenges seemed to impact some men’s sense of self in their adult lives, as exemplified by this quote from a participant in a Norwegian study exploring substance abuse and suicide in men: “Since I was quite small I was told (by his father) that ‘you won’t amount to anything’. Even now, when I encounter new situations, his words come back to me (…)” (p. 251, Biong & Ravndal, 2007).

3.4.3.2.4 Suicide Associated With Killing of a Failed Self

In 46% of studies, from lower-, middle- and upper-income settings, a profound sense of personal failure, of not meeting social expectations for men, and experiencing an unbearable loss of status and social value were described as proximal drivers of suicidal behaviours in men (Andoh-Arthur et al., 2018; Oliffe et al., 2017; Rasmussen et al., 2018). Some men appeared to struggle to regulate setbacks in life. Defeats seemed not to be contextualized but

interpreted as something damning about them as individual men and to symbolize a total failure of their personhood. For some participants, suicide was reported as the desire to escape a failed, defeated, broken, shamed and/or hated self who has lost all social status and social value (Everall et al., 2006; Kizza et al., 2012; Rasmussen et al., 2018). A Brazilian man described his suicide attempt as such: "I tried to set up a business for myself and my family and it didn't work. I lost money and there was no other alternative except killing myself" (p. 5, Ribeiro et al., 2016). A UK father, whose young son died by suicide, remarked that in his suicide note his son spoke of his negative sense of self: "It was very much that, he'd been given everything and he didn't live up to everything, and very, very critical of himself" (p. 262, Bell et al., 2010).

3.4.3.2.5 Suicide Associated With Regaining of Control

In 14% of papers, suicide was described as a way to potentially reclaim control over a failed life in freefall, the opportunity to return a defeated self to a place of dignity and to watch over and protect loved ones (Kjolseth et al., 2009; Meneghel et al., 2012; Rasmussen et al., 2018). In a Norwegian study, a young man wrote in his suicide note: "When in heaven, I'll watch over you and look after you. It will be my job" (p. 338, Rasmussen et al., 2018). Similarly, a 38-year-old man from a study in Australia, diagnosed with depression and who had no contact with mental health services prior to his attempt remarked: "When you are completely disempowered, the only way you can empower yourself is to take your own life" (p. 153, Fitzpatrick, 2014).

3.4.3.2.6 Summary

In 76% of studies, failing to meet norms of male success appeared to be associated with increased psychological pain and suicide risk. The perceived pressure to meet norms of male success and to be a man of social value were associated with feelings of failure, and disconnection from self. Denial, disconnection, and dysregulation in the domain of selfhood appeared to 1) increase some men's psychological pain and 2) diminish their ability to regulate that pain effectively, potentially elevating suicide risk (see Figure 3.2). Many men described aversive self-awareness in relation to a perceived 'othered' or 'failed' aspect/s of their masculine identity. Some men created a performance of self to conceal distress and maintain a masculine front of coping. For men who experienced adversity in childhood, their self-esteem may have been further undermined by early-life challenges. In a proximal context

messages of successful male selves were perceived to be so strong, that lacking them seemed to be understood by some men as a total failure of personhood. Suicide was described by some men as the drive to kill a failed, broken, defeated and/or hated self. To a lesser extent, suicide was also associated with the desire to regain control over a life in freefall.

3.4.3.3.2 Norms that Suppress Men's Interpersonal Needs

Norms that suppress men's interpersonal needs were associated with increased psychological pain and suicide risk in 82% of papers. This analytical theme is broken down into 6 descriptive themes.

3.4.3.3.1 Interpersonal Disconnection, Isolation and Loneliness

In 46% of papers, we saw evidence to suggest masculine norms that devalue and suppress meaningful interpersonal connection, were associated with painful feelings of isolation and loneliness. Norms of male independence, self-reliance and autonomy appeared to keep some men separate from others. Norms of emotional suppression and non-disclosure were described as keeping some men from sharing their intimate struggles with others. As such, men who are suicidal were potentially left disconnected from the renewing properties of interpersonal intimacy. Across cultural contexts, a lack of meaningful social and emotional connection was described as a source of anguish for many men as they found themselves alone with their pain (Biong & Ravndal, 2009; Player et al., 2015). A 27-year-old Canadian man who attempted suicide described his social isolation as such: "(…) I've never felt that hollow inside. I really felt that I was dead and I didn't have anyone to reach out to" (p. 380, Everall et al., 2006).

Isolation and loneliness were referenced in different contexts. Some men described feeling alone with their pain (Cavalcante & Minayo, 2015; Cleary, 2012; Oliffe et al., 2017) or suppressed childhood trauma (Kiamanesh et al., 2014; Oliffe et al., 2019). Other men described feeling rejected/excluded or not belonging (Biong & Ravndal, 2009; Gajwani et al., 2018; Rivers et al., 2018). Other men perceived themselves to be isolated because they were afraid their inadequacies would be exposed if anyone got too close (Meissner & Bantjes, 2017; Oliffe et al., 2017), or they described that they did not know how to repair damaged interpersonal dynamics or build intimacy with others (Gajwani et al., 2018; Rasmussen et al.,

2018; Strike et al., 2006). The causes of isolation and loneliness are complex and nuanced, and experienced at both the individual level - such as family estrangement (Biong & Ravndal, 2007; Elliott-Groves, 2018) - as well as the community/cultural level. For some men, isolation seemed to stem from the stigma they felt in relation to their mental health challenges (Oliffe et al., 2017) or sexuality (Ferlatte et al., 2019; McAndrew & Warne, 2010; Rivers et al., 2018). Isolation for sexual minority men could be further compounded if they later experienced rejection from within the LGBTIQ community, for example, older gay men described feeling erased by younger generations (Stanley et al., 2009). For immigrant men, a lack of belonging to both their country of origin and host country was described (Biong & Ravndal, 2009; Ferlatte et al., 2019). For men in the Cowichan community, a rupture with traditional cultural life appeared to leave some men isolated from roots and identity (Elliott-Groves, 2018). Male migrant workers in Nepal, seemed to struggle to reintegrate back in their families after being away for work (Hagaman et al., 2018). For older men, isolation appeared to stem from a loss of purpose, status and perceived value to others (Cavalcante & Minayo, 2015; Kjolseth et al., 2009; Knizek & Hjelmeland, 2018).

Isolation and loneliness as potential distal suicide risk did not just apply to men visibly excluded. Many men who are suicidal were described as embedded in networks of relationships and were either concealing their emotional reality from the people around them or felt they did not have the tools to articulate their pain, and were thus potentially isolated from aspects of meaningful, intimate connection (Cleary, 2012; Chung et al., 2015; Oliffe et al., 2017). Significant others also suggested that the tendency for some men who are suicidal to not disclose their emotional reality, contributed to perceived emotional distance in their dynamics (Creighton et al., 2017; Kiamanesh et al., 2014; Kjolseth et al., 2009). Men who appeared closed off, independent and private, were described as difficult to approach, or their anger could potentially alienate them from others (Creighton, et al., 2017; Kiamanesh et al., 2015). A participant bereaved by an elderly man's suicide in a Norwegian study, commented: "He never opened himself to us, never showed his feelings" (p. 907, Kjlseth et al., 2009).

3.4.3.3.2 Interpersonal Challenges and Dysregulation

In 28% of papers, we found evidence to suggest that challenges and conflict in interpersonal relating were associated with interpersonal dysregulation and appeared to amplify emotional isolation, feelings of failure and psychological pain (Biong & Ravndal., 2007; Rasmussen et

al., 2018). Conforming to masculine norms such as emotional suppression and self-reliance, seemed to leave some men ill-equipped to build, sustain and manage intimate interpersonal relationships (Kiamanesh et al., 2015; Kjolseth et al., 2009; Sweeney et al., 2015). A sibling from a Norwegian study whose brother died by suicide remarked: “he thought it was incredibly difficult with girls. He didn’t quite know how to go forward ... how to create a stable relationship” (p. 226, Rasmussen et al., 2018).

Problems in the interpersonal realm were broad and included perceived difficulties for some men in expressing and receiving care (Kjolseth et al., 2009; Kunde et al; 2018; Strike et al., 2006), challenges in dealing with interpersonal stresses and conflict (Chung et al., 2015; Kunde et al., 2018, Stanley et al., 2009), problems navigating intimacy and vulnerability (Rasmussen et al., 2018; Stanley et al., 2009), a dogged and alienating need for control and self-reliance (Kiamanesh, et al., 2015; Kjolseth et al., 2009) and/or moody and angry behaviour that appeared to alienate others (Costa & de Souza, 2017; Fogarty et al., 2018; Player et al., 2015). A 26-year-old man in Australia who attempted suicide recalled: “I became so moody and unpredictable that nobody wanted to intervene because they didn’t know what direction that would send me” (p. 7, Player et al., 2015).

In other studies, men with low self-esteem were described as maladaptively dependent on external validation (Kiamanesh et al., 2015; Rasmussen et al., 2018). Pain-relief behaviours referenced earlier, such as excessive drinking, could also potentially lead to irresponsible, disordered and sometimes violent behaviour that put interpersonal relationships under strain (Akotia et al., 2019; Fogarty et al., 2018; Ziółkowska & Galasiński, 2017). This man from a Brazilian study looking at alcohol and drug use in men who had attempted suicide described how his addiction impacted his relationships: “I was heart broken, I had a fiancée, and then I had a relationship with a person that didn’t work either... alcoholism makes us aggressive, unable to accept things... I’m a lousy loser” (p. 5, Ribeiro et al., 2016).

3.4.3.3.3 Struggling to Trust

In 14% of papers, men described challenges trusting others as impairing their ability to create meaningful connections, and this mistrust seemed to compound isolation and interpersonal challenges (Chung at al., 2015; Gajwani et al., 2018; Mackenzie at al., 2018). A young Irish man who had attempted suicide remarked: “I didn't trust anybody, I didn't even trust me ma”

(p.171, Cleary, 2005). Similarly, a woman bereaved by her boyfriend's suicide in a Norwegian study remarked: "He was afraid to let people get too close to him ...I believe that was a survival mechanism (…) he has had so many tough experiences through his life ... he learned very early to just shut off, sharply (…)" (p. 138, Kiamanesh et al., 2015).

3.4.3.3.4 Suicide Associated With Interpersonal Stressors and Losses

In 42% of papers within this review, before a suicidal act, participants described proximal interpersonal stressors or losses. These were primarily relationship problems or breakdowns (Kunde et al, 2018; Peters et al., 2013; Rasmussen et al., 2014; Stanley et al., 2009), though family conflict (Kiamanesh et al., 2015; Meissner & Bantjes, 2017; Salway & Gesink, 2018) and bereavements were also cited (Ghio et al., 2011; Fitzpatrick, 2014; Rivlin at al., 2013). These pre-suicide stressors were not considered significant on their own, so much as representing the last straw in an accumulation of unresolved psychological pain that became intolerable (Player et al., 2015; Rivlin et al., 2013). A participant bereaved by suicide in a Ghanian study described how his friend who died by suicide was: "(…) always talking about death. He said he would die because the wife had left him" (p. 661, Andoh-Arthur et al., 2018). Similarly, an Australian participant whose son died by suicide commented:

> "He had a fight with his girlfriend that morning. ... He was drunk ... her [girlfriend's] mother come out and said is [son] there, because they couldn't get in contact with him. I said no. She said check the garage. So he [husband] checked the garage and that was it" (p. 313, Peters et al., 2013).

3.4.3.3.5 Suicide Associated With Unbearable Isolation and Loneliness

In 23% of studies, overwhelming social isolation, loneliness, and a lack of belonging and meaningful connection were associated with proximal drivers of suicidal behaviours (Cavalcante & Minayo, 2015; Oliffe et al., 2017; Rasmussen et al., 2014). A Brazilian man who attempted suicide described: "My family slowly abandoned me, or rather, I abandoned them and ended up alone [...] and I would often get depressed, drink, use drugs and would really feel like ending it, end all the suffering that my life had become" (p. 4, Ribeiro, 2016). Similarly, a Canadian man remarked: "(…) I'm not adding to anybody else's life. I can go for months and years without talking to family members, so you know, if I'm here or if I'm not here, what difference does it make (…)" (p. 318, Oliffe et al., 2019).

3.4.3.3.6 Suicide Associated with Perceived Burdensomeness

In 8% of papers, suicide was associated with a desire to stop being a burden on loved ones. These feelings of burdensomeness appeared to be linked to feelings of shame, feeling useless, self-contempt and not living up to cultural expectations (Hagaman et al., 2018; Knizek et al., 2018; Ribeiro et al., 2016). This man from a Brazilian study looking at alcohol and drug use in men who attempt suicide described:

> "I believed I was this useless person to society and a burden on my family. I thought that that would bring them some peace (family), since they thought the problem was all me. So, I thought that I could stop the suffering and stop their suffering as well" (p. 4, Ribeiro et al., 2016).

3.4.3.3.7 Proximal Indicators of Suicide Risk Challenging to Read

Significant others are often closest to men in the days leading up to an attempted or completed suicide. Indicators of suicide risk appeared to vary, with distress described as visible in some men and not in others (Fogarty et al., 2018; Owen et al., 2012; Sweeney et al., 2015). Where struggles were known, the behaviour of men who are suicidal was described as erratic, making it difficult for significant others to interpret signs of acute distress (Kiamanesh et al., 2015; Owen et al., 2012; Sweeney et al., 2015). Men who are suicidal were described as hard to reach (Owens et al., 2011) and could respond aggressively when approached about their state of mind meaning suicidal despair could potentially be misread as anger or men actively resisted professional intervention (Fogarty et al., 2018; Player et al., 2015). Some significant others felt men lacked the emotional communication skills necessary to articulate their pain or it was communicated without the expected emotional valence to indicate profound distress (Owen et al., 2012; Owens et al., 2011). Some men were reported as only disclosing feelings of suicide in jest, or when drunk (Owen et al., 2012). Other friends and family described how some men talked about suicide frequently, and so they acclimatized to their loved one's despair such that extreme behaviours ceased to be disturbing or worrying (Owens et al., 2005). This male participant from a UK study shared how his friend who died by suicide would frame his thoughts of suicide:

> "And he'd say it with a smile, or he'd say it just as you'd say hello to someone, or he made a joke of it. [. . .] It would be no big deal. It's just something that would come

> up in conversation . . . There was no real emotion or anything behind it" (p. 425, Owen et al., 2012).

In the absence of behaviour that friends and family associated with 'mental illness' they often did not think their loved one was a suicide risk (Owens et al., 2005; Sweeney et al., 2015). Suicide disclosures were sometimes rationalized as a natural response to acute life stressors (Owens et al., 2005), and friends and family may have been reticent to pathologize their loved one's behaviour or lacked the confidence and skills to know how to intervene (Owens et al., 2011). Some male friends described their friendships as centred around "light-hearted, fun interaction and banter" (p. 153, Sweeney et al., 2015) and felt they lacked the emotional tools to know how to intervene when they perceived a friend struggling (Cleary, 2005; Owens et al., 2011; Sweeney et al., 2015). In studies where men were not in contact with mental health services, an intense burden of care appeared to rest with significant others. Sometimes loved ones were the only people aware of a man's distress and had to manage the pressure of assessing risk escalation (Owens et al., 2011; Peters et al., 2013). Other families appeared to provide 24/7 care for some men who left hospital after an attempt and described feeling isolated by this "hyper responsibility" which took a toll on their own mental health (Owens et al., 2011; Peters et al., 2013). An Australian man, whose nephew died by suicide, described how his family would be on 'suicide watch' for several months:

> "Suicide watch sort of consisted of sitting in front of the telly, which was outside his bedroom, and just pretending to watch telly (…) turning the volume down really low, and just being in tune and in check with the different noises that were happening in his bedroom" (p. 312, Peters et al., 2013).

At the other end of the spectrum, many other men appeared to keep their distress so concealed that significant others described having no prior warning of suicide risk. Bereaved families shared that men showed no external signs of mental distress (Rasmussen et al., 2018; Sweeney et al., 2015) and concealed their despair so effectively that they seemed popular, social, upbeat, and the possibility of their suicide inconceivable (Kiamanesh, et al., 2014; Oliffe et al., 2018; Rasmussen et al., 2014). A 26-year-old male participant in Ireland, whose friend died by suicide described his friend as follows:

> "He'd be able to talk to anybody, and if you were in a pub or a club or whatever, he'd go up and talk to anyone ... he definitely would never strike you as someone who would do that [suicide]" (Sweeney et al., 2015, p. 155).

3.4.3.3.8 Summary

In 82% of studies, we found evidence to suggest masculine norms that seem to devalue and suppress men's interpersonal needs were associated with denial, disconnection, and dysregulation in some men's interpersonal dynamics. These processes appeared to 1) increase some men's psychological pain and 2) diminish their ability to regulate that pain effectively, potentially elevating suicide risk (see Figure 3.2). Masculine norms such as emotional suppression, and the need for men to be independent and autonomous, appeared to impact some men's relationships leaving some men isolated, and/or struggling to trust others, and/or ill-equipped to regulate interpersonal intimacy and challenges. In a proximal context, the dysregulation of men's interpersonal needs was associated with intolerable isolation and relationship challenges and to a lesser extent perceived burdensomeness. Masculine norms were described as making proximal indicators of suicide potentially challenging for significant others to read and respond to, and in some instances appeared to render indicators of acute suicidality invisible.

3.4.4.4 Regulating Psychological Pain and Suicide Recovery

Evidence for recovery factors generated 263 codes categorized into one analytical theme and five descriptive themes. Findings appeared to centre around men learning to recognize, reconnect with and regulate their emotions, relationship with self and interpersonal connections. These processes appeared to help increase some men's ability to regulate their psychological pain more effectively, which we suggest helps reduce suicide risk. We have synthesized these thematic findings in Figure 3.3, '3 'R' Recovery'.

3.4.4.4.1 Emotional Regulation and Control

The immediate aftermath of a suicide attempt was described by participants as an emotionally volatile time (Ghio et al., 2011; Owens et al., 2011; Rivlin et al., 2013). For some men, the most painful and distressing feelings they'd been concealing about themselves - that they are

a ‘failure’, that their existence is no longer bearable, that they cannot cope - were suddenly visible to the world. One participant remarked that after his attempt he felt like he was walking around with all his clothes off (Wiklander et al., 2003). Post-attempt, men cited emotions such as anger (Ghio et al., 2011; Rivlin et al., 2013; Vatne & Naden, 2014), disappointment that they were still alive (Ghio et al., 2011; Rivlin et al., 2013), guilt towards significant others (Akotia et al., 2014; Ghio et al., 2011; Vatne & Naden, 2012), frustration (Rivlin et al., 2013), distress (Wiklander et al., 2003), shame, embarrassment and fear (Knizek & Hjelmeland, 2018; Tzeng, 2001; Vatne & Naden, 2016). These feelings seemed to create a seascape of rapidly changing and volatile emotional states. In 47% of studies, men described learning to recognize, reconnect with, and regulate their emotions and psychological pain as potentially important for helping them manage their thoughts of suicide (Biong & Ravndal, 2007; Ferlatte et al., 2019; Mackenzie et al., 2018). Reference was made to talking to a psychiatrist/psychologist/counsellor (Ferlatte et al., 2019; Gajwani et al., 2018; Mackenzie et al., 2018), Cognitive Behavioral Therapy (Jordan et al., 2012), peer support (Ferlatte et al., 2019; Gajwani et al, 2018; Ghio et al., 2011), significant others (Tryggvadottir et al., 2019), or prison staff (Rivlin et al., 2013). A young Australian man who attempted suicide twice and had a negative experience with one professional who framed his distress as mental illness, eventually found support from a psychologist whose person-centred approach appeared to help him: “I felt better instantly because, for no other reason than, I had someone I could talk to, share feelings” (p. 154, River, 2018).

Details of the specific mechanisms of these processes were scarce but these interactions were described as helping men learn to understand, communicate and manage their emotions (Meissner & Bantjes, 2017; Player et al., 2015; River, 2018), accept and manage suicidal behaviours (Ferlatte et al., 2019; Jordan et al., 2012; Meissner & Bantjes, 2017), reconcile with their pasts (Biong & Ravndal, 2007; Jordan et al., 2012; Vatne & Naden, 2014), and develop a new narrative of self and social value (Fogarty et al., 2018; Fitzpatrick, 2014; Rasmussen et al., 2018). Learning to identify and communicate problems and emotions (Byng et al., 2015; Pavulans et al., 2012), and understanding triggers for distress and tools for regulating it appeared to help give some men a degree of agency and control back over their lives (Fogarty et al., 2018; Oliffe et al., 2017; Vatne et al., 2018).

Study authors reflected on the need for greater awareness of how masculine norms potentially influence men’s emotional and cognitive patterns of behaviour and working therapeutically

with these schemas (Biong & Ravndal, 2007; Kunde et al., 2018; Tryggvadottir et al., 2019), particularly around men's feelings of failure and shame (Andoh-Arthur et al., 2018) and expanding men's notions of what constitutes a successful man (Jordan et al., 2012). A 38-year-old Australian man who attempted suicide, remarked: "I hope that I can disable this narrative of failure which has become, as my psychologist said yesterday, more or less self–fulfilling." (p. 154, Fitzpatrick, 2014)

3.4.4.4.2 Interpersonal Care and Connection

In 32% of studies, participants described recognizing their need for social belonging and reconnecting with significant others as helping to strengthen their desire to live (Jordan et al., 2012; Mackenzie et al., 2018; Player et al., 2015). Feeling that their lives mattered and held meaning for people and becoming aware of their emotional responsibilities to others appeared to help anchor some men back in existence (Biong & Ravndal, 2007; Mackenzie et al., 2018; Vatne & Naden, 2016). This is potentially critical when men were still oscillating between suicidal action (Biong & Ravndal, 2007; Sellin et al., 2017). These bonds were primarily with family (Jordan et al., 2012; Sellin et al., 2017; Tzeng, 2001), as well as friends (Ferlatte et al., 2019; Vatne & Naden, 2016), teachers and peers (Fenaughty & Harré, 2003), and God and religion (Biong & Ravndal, 2007; Osafo et al., 2015). A man from a Swedish study, admitted to psychiatric unit for his suicide risk, commented: "I have learnt that I have great social needs and that it is easier to handle yourself if you have friends and relatives" (p. 204, Sellin et al., 2017). Similarly, a 23-year-old gay man from South Africa remarked on the impact his suicide attempt had on his family: "I saw how upset it made my whole family (…) Sometimes you find yourself in such a dark space ... you don't see that there is actually people that are loving, that can help you" (p. 791, Meissner & Bantjes, 2017).

3.4.4.4.3 Peer Connection and Expanding Masculine Selves

In 24% of studies, men described the importance of sharing their lived experiences with other people who are suicidal through peer support groups (Ferlatte et al., 2019; Gajwani et al., 2018; Ghio et al., 2011). Listening to other men in particular disclose their struggles and share tips on dealing with suicidal behaviours, seemed to help change participants' perceptions of masculinity. These connections appeared to help normalize men's pain and alleviate some of their shame (Ferlatte et al., 2019; Jordan et al., 2012; Vatne & Naden,

2018). A participant from a Canadian study looking at suicide prevention in gay, bisexual and two-spirited men, commented how sharing his experiences of suicide with peers had helped him:

> "I find one of the most useful things that I've done too, is like, talking with other people who have had similar experiences to me. . . . It just feels like validating hearing somebody else talk about things. You're like, "I get that, too" (p. 1192, Ferlatte et al., 2019).

Peers who were successfully rebuilding their lives were described by some as role models who embodied a hope-filled future (Ferlatte et al., 2019; Jordan et al., 2012; Tryggvadottir et al., 2019). Opportunities to be of service to other men who are suicidal through peer groups and volunteering within the wider community, also seemed to bolster some men's self-worth, and appeared to help provide purpose and meaning (Jordan et al., 2012; Ghio et al., 2011). The importance of expansive representations of masculinity were also described. At the individual level, friends and families cited the importance of normalizing men expressing vulnerability and struggles (Creighton et al., 2017; Oliffe et al., 2018). At the cultural/community level, public framings of masculinity were described as needing to represent more expansive embodiments for male possibilities (Andoh-Arthur et al., 2018; Creighton et al., 2017). A father in Canada, whose son died by suicide, remarked how he wished he had displayed more of his own vulnerability: "(…) I didn't think about all the stuff that I could have taught him. "What would I handle differently?" It would be about vulnerability for myself" (p. 1387, Oliffe et al., 2018).

3.4.4.4.4 Being Respected and Valued by Professionals

In 19% of papers, participants described how the intervention of empathetic, compassionate, and attentive professionals was a valuable protective factor and seemed to help breach some of their isolation (Gajwani et al., 2018; Jordan et al., 2012; Vatne & Naden, 2018). Non-judgemental listening (Biong & Ravndal, 2007; Ferlatte et al., 2019; Jordan et al., 2012), being shown respect (Vatne & Naden, 2016; Wiklander et al., 2003), given time (Kjolseth et al., 2009), seen as valuable and cared about (Vatne & Naden, 2018) and treated as an equal (Jordan et al., 2012; Vatne & Naden, 2014) appeared to increase participants' sense that they were worthy of someone's time and attention. Talking about his doctor, a Norwegian man,

aged between 32 and 40, who had been suicidal and suffered substance abuse, said: “He believed in me and listened to me. That meant a lot and was one of the reasons why I managed to go on” (p. 253, Biong & Ravndal, 2007). A young man in an Irish study spoke of the difference a mental health professional made: “Honestly? He listened to me. He heard what I was saying” (p. 1211, Jordan et al., 2012).

3.4.4.4.5 Contextualized Suicidal Pain

In 31% of studies, participants and authors discussed the need for suicidal pain to be understood beyond individual psychopathology paradigms (Kunde et al., 2018; Meissner & Bantjes, 2017; River, 2018). Suicidal thoughts and behaviours were described as tied to cultural, political and social norms and values, structural factors, as well as lived experiences that shape the suicidal mind and that these need to be understood and explored to help resolve aspects of suicidal pain (Akotia et al., 2019; Fitzpatrick et al., 2014; Kunde et al., 2018; Laubschler, 2003). An Australian man who perceived his suicide attempt as driven by a lack of secure and fulfilling work, and who was told by a psychologist that he was depressed, spoke of his anger at this response: “that really pisses me off, because there are a lot of people out there really struggling and just being classed as depressive” (p. 154, River, 2018).

3.4.4.4.6 Summary

In 78% of studies, we found evidence to suggest that recovery factors related to men recognizing, reconnecting with, and regulating aspects of their emotions, self-hood and interpersonal connections seemed to help men regulate their psychological pain more effectively, which we suggest helps reduce suicide risk (see Figure 3.3).

3.5 Discussion

To our knowledge, this qualitative meta-synthesis is the most in-depth review of qualitative male suicide research yet conducted. It is based on the analysis of 78 peer-reviewed studies that encapsulate insights from over 1,695 people close to the phenomena.

3.5.1 Norms of Masculinity and Male Suicide Risk

In 96% of papers, we identified an association between cultural norms of masculinity and male suicide risk. It is important to emphasize that these findings relate to masculinity as "a social construction distinct from male biological sex" (p. 15, Levant & Pryor, 2020). Our findings do not problematize the male sex but cultural norms that may narrow some men's behavioural repertoires with potentially profoundly detrimental costs to their psychological health (Lee & Owens, 2002). Masculinity is not pathological (Kryinska, 2014; Seidler et al., 2018), and most men are not suicidal. Similarly, many norms traditionally associated with masculinity, such as provision and protection, are admirable qualities that have made a valuable contribution to the human story (Kiselica & Englar-Carlson, 2010). However, our review suggests certain pressures imbued in expectations of masculinity may increase some men's suicide risk and understanding this dynamic may be a critical component of male suicide prevention work.

In our review, norms relating to male emotional suppression, failing to meet standards of male success and the devaluing of men's interpersonal needs were associated with some men experiencing denial, disconnection, and dysregulation within three core psychological domains: 1) emotions (92% of papers), 2) self (76% of papers), and 3) interpersonal connections (82% of papers). These processes appeared to be associated with 1) increasing men's psychological pain, and 2) diminishing men's ability to regulate that pain, which we suggest elevates suicide risk. In our review, recovery was framed as learning to regulate psychological pain through recognizing, reconnecting and regulating emotions, thoughts and feelings towards self and connections with others. To elucidate these dynamics, we developed two models (3 'D' Risk and 3 'R' Recovery). These models do not seek to diminish the huge complexity of suicide. Like Leenaars (1996), we wish to caution that each man who is suicidal must be understood individually. Failure may be a core dynamic in male suicide, but the causes of that perceived failure will be unique to the individual. Each suicide is an individual story, with its own context and biography.

Our findings accord with quantitative evidence to suggest the potential importance of psychological pain, emotions, self, connections with others and masculine norms to suicide. A recent systematic review of mental pain in 42 studies concluded it was a significant predictor of suicide risk (Verrocchio et al., 2016). Recent systematic reviews also indicate that higher levels of emotional intelligence protect against suicide (Domínguez-García & Fernández-Berrocal, 2018), and challenges regulating emotions are associated with suicidal

behaviours (Colmenero-Navarrete et al., 2021). A recent mini-review and meta-analysis found an association between alexithymia - a condition by which people struggle or are unable to distinguish/identify emotions - and suicidal risk and ideation (De Berardis et al., 2017; Hemming et al., 2019). Problems sharing feelings have been found to be more predictive of a medically serious suicide attempt than depression or hopelessness (Levi et al., 2008).

Quantitative studies have also explored the link between feelings towards self and suicidal behaviours, with shame and low self-esteem associated with suicide (Bhar et al., 2008; Cameron et al., 2020; Chatard et al., 2009; Soto-Sanz et al., 2019; Thompson, 2010). A recent machine learning study found levels of self-esteem to be an important predictor of suicidal thoughts and behaviours (Macalli et al., 2021). Additionally, the quantitative evidence for a lack of social bonds as a suicide risk for men is well supported. Relationship breakdowns are frequently cited as a trigger for suicidal behaviours in men (Goodman et al., 2020; Hardy, 2019; Samaritans, 2012; Scourfield & Evans, 2015). A meta-analysis found men who were not married demonstrated a higher likelihood of suicide compared to men who were married (Kyung-Sook et al., 2018). Conversely, a recent study of Australian men found that interpersonal connections, resilience and coping behaviours protected against suicidal ideation and planning in men (Seidler et al., 2023). Finally, adherence to traditional masculine values has been found to increase suicide risk in men (Coleman, 2015; Houle, Mishara & Chagnon, 2008). In particular, masculine norms of stoicism (Daruwala et al., 2021) and self-reliance have been associated with suicidal ideation in men (King et al., 2020; Pirkis et al., 2017).

3.5.2 Interacting Harms

Our review has presented evidence to suggest a potential association between masculine norms and increased male suicide risk. However, given that most men socialised in these same norms do not engage in suicidal behaviours an urgent key question remains as to why these norms are a potential risk for some men. One possible explanation may be that it is the interaction and accumulation of harms across the domains of emotions, self, and interpersonal connections that raise some men's suicide risk.

In this review, we have conceptually separated these psychological domains to illustrate how masculine norms are potentially associated with harm in each domain. However, these constructs cannot be understood in isolation. They are inextricably linked and reciprocal i.e., our emotional states, our thoughts and feelings toward self, and our interpersonal connections are informed and affected by each other (Barrett, 2017; Farberow, 2004; Smith & Weihs, 2019). Harm in one domain can aggravate and extend harm in the others (Bryan & Rudd, 2016). Themes relating to denial, disconnection and dysregulation of emotions AND self AND interpersonal connections featured in 65% of studies. In multiple ways, these domains appeared to interact. Feelings of failure were associated with men socially withdrawing and isolating themselves (Biong & Ravndal, 2009; Tryggvadottir et al., 2019). Feeling like a failure was associated with men intensifying emotional suppression as “the only masculine act available" (p. 893, Oliffe et al., 2017). Emotional suppression was associated with leaving men isolated from themselves and others (Biong & Ravndal, 2007) and coping through alcohol (Cleary, 2012). Alcohol dysregulation was associated with increased tension and isolation in interpersonal relationships and driving suicidal behaviour (Knizek & Hjelmeland, 2018). Thinking about suicide was associated with exasperating men’s feelings of failure and isolation (Tryggvadottir et al., 2019). See Table 3.2, and Appendix 3.8 for additional quotes from primary studies to illustrate how these harms interact.

Table 3.2 *Quotes illustrating the interaction of emotions, self and interpersonal connections*

Interaction of:	**Supporting Evidence**
Emotions and Self	"A continual negative relationship to the self [self-aversion] seemed to influence both their earlier and current troubles and created emotional problems for the participants in their daily lives [emotional dysregulation]." (p. 251, Biong & Ravndal, 2007)
Emotions and Interpersonal Connections	"There is no one who understands my feelings [interpersonal isolation]. I have hidden my problems from others [emotional suppression]. As a result, I have never asked for help, and I do feel very lonely [interpersonal isolation]." (p. 359, Chung at al., 2015)
Self and Interpersonal Connections	"I always used to stay in bed and say I hate myself [self-aversion]. I wouldn't take a bath for days . . . I wouldn't go out. I wouldn't even socialize with people [interpersonal isolation]." (p. 33, Strike et al., 2006)
Emotions, Self and Interpersonal Connections	"Our informants suggested that these six men became suicidal when suddenly faced with unexpected events within significant areas of life, namely work and intimate relationships [interpersonal challenges], which in turn led to a crack in their façade [performance of self undermined]. Thus, they seemed to have experienced themselves as totally defeated [self as defeated], and they showed highly reduced emotional and cognitive capacity toward the end of their lives [emotional dysregulation]" (p. 321, Kiamanesh et al., 2015)

We suggest some men who are suicidal are potentially trapped in these pain loops, with harms in core domains possibly reinforcing each other, and potentially increasing men's psychological pain and diminishing their resources to regulate it effectively. It is therefore important to view the risk factors suggested in this review not as discrete, solitary components but as psychological mechanisms in potential reciprocal, dynamic and fluctuating interaction. We speculate that this interaction may set the dynamic psychological context for male suicide and potentially provide a more compelling explanation for the role of cultural norms in male suicide risk. We cannot present a linear story for how that interaction evolves, it will be unique to each individual (Rudd, 2000). However, we believe that exploring the interaction of potential harms within these core domains in an individualised context could help bring personal male suicidal narratives and risk to life. For example, a man who loses his job but has good emotional regulation and interpersonal connections where he is meaningfully known and supported is potentially buffered from suicide risk compared to a man who loses his job, has emotional dysregulation, denies his interpersonal needs and is emotionally isolated. Losing a job can be a source of psychological pain. In this second scenario, other harms to a man's emotional regulation and interpersonal connections may undermine his ability to effectively regulate this pain. Suicide risk will be mediated by other factors, i.e., genetics, personality traits, hormones etc. We do not claim that this explanation is exhaustive, only that the interaction of cultural harms may contribute to elevating some men's suicide risk.

3.5.3 Childhood Adversity, Masculine Norms and Suicide Risk

Childhood adversity was also associated with distal suicide risk in 56% of studies and appeared to impact men's emotional development (Biong & Ravndal, 2009; Chung at al., 2015; Everall et al., 2006) and self-worth (Biong & Ravndal, 2009; Kiamanesh et al., 2014; Salway & Gesink, 2018). Childhood adversity is a well-established distal risk factor (Harris, 2010; Joiner, 2005; O'Connor & Kirtley, 2018; Turecki et al., 2019; Zortea et al., 2019). What is potentially significant from this review is thinking about how childhood adversities may interact with masculine norms to potentially compound men's risk. Men who experience childhood challenges and are socialised to suppress pain, may face a double jeopardy in terms of developing robust emotional regulation. Research has also shown that men who experience child abuse and high masculine norm conformity are at increased odds of a suicide attempt (Easton et al., 2013).

Over 96% of childhood adversity codes came from upper-income contexts. Concrete cultural comparisons cannot be established from this review as different researchers investigated and asked different questions, but the absence of childhood challenges in some locations may potentially reflect different cultural contexts. Poverty and instability are potentially the primary focus of daily concerns and sources of emotional turmoil outside of upper income locations. In westernised contexts, relative material comfort has potentially allowed a cultural re-orientation towards a more nuanced awareness of individual, childhood neglect and adversity (Dowbiggin, 2011). It is also worth noting that given male norms to suppress emotions, the studies reviewed may not provide an accurate insight into the childhood adversity experienced by participants. For example, Gajwani et al. (2018) observed that participants described largely "happy childhoods" even though narratives also referenced profound adversity that was "experienced as intrusive flashbacks" in adulthood (p. 1122). This potential dissonance may be a product of cultural norms of male stoicism and may distort men's recollection and permissions/safety to articulate the impact of adversity.

3.5.4 Understanding Distal and Proximal Risk

In our findings, proximal risk factors appeared to be an intensification of the denial, disconnection and dysregulation of emotions, self and interpersonal connections that were identified as distal risk. Causality cannot be inferred from our data. In particular, our proximal distinctions are crude and there was not clear information about how proximal they were i.e., hours, days or weeks before an attempt/death. However, it could be that there are core psychological phenomena critical to human well-being that both distal and proximal risk factors progressively undermine. Our data suggest these domains to be emotions, self and connections with others. Exposure to risk factors that deteriorate functioning in these domains could elevate suicide risk over time and suicide prevention work may need to help men achieve effective regulation in these areas. Similarly, it may be difficult to accurately delineate what constitutes a distal risk factor from a proximal risk factor. A middle-aged man who experienced childhood sexual abuse may lose his job and make a suicide attempt immediately after. His job loss may be the proximal factor that precipitates his attempt, but traumatic thoughts relating to the abuse may be most prevalent in his mind as he attempts.

While some researchers have suggested distinguishing between risk factors for suicidal ideation and suicide attempts (Glenn et al., 2017), other scholars suggest that suicide should not be viewed as a linear process. Instead, suicide attempts may be an amalgamation of long- and short-term risk factors with thoughts of suicide and attempts emerging "at once, or within a short lapse of time" (p. 915, Bloch-Elkouby et al., 2020). Our findings suggest support for both views as the level of planning before an attempt appeared to differ. Some men referenced planning their suicide for years (Biong & Ravndal, 2009; Rasmussen et al., 2014) others suggested they only thought about it a few minutes before attempting (Rivlin et al., 2013). Our review did suggest there may be some behavioural presentations in men experiencing profound dysregulated psychological pain that may indicate the threshold for tolerating pain is at risk of being breached. Men's interiors were described as exhausting to inhabit as they struggled to regulate thoughts and feelings of suicide (Cleary, 2012; Kiamanesh et al., 2015; Oliffe et al., 2018). Men described feelings of panic (Cleary, 2012), dysregulated thoughts and decision-making (Biong & Ravndal, 2007), sleep problems (Benson et al., 2016; Oliffe et al., 2019), insomnia (Bonnewyn et al., 2014), anxiety (Bonnewyn et al., 2014), exhaustion (Biong & Ravndal, 2009; Oliffe et al., 2017), diminished self-regulation and coping resources (Benson et al., 2016; Rasmussen et al., 2018). Understanding the psychobiology of psychological pain could help elucidate useful distal and proximal distinctions. As Sher (2020) remarks, we won't "reduce suicide in men until we have a good grasp of the psychobiology of suicide in men" (p. 277).

3.5.5 Understanding the Suicide Gender Paradox

What value does our review add to understanding why men are more at risk of dying by suicide than women? From a psychological perspective, our findings suggest that denial, disconnection and dysregulation of emotions, self and interpersonal connections are potentially associated with male suicide. However, these core dynamics could also be active in female suicide risk. In fact, we found similar themes present in studies with mixed suicidal populations, including emotional dysregulation (Everall et al., 2006; Fitzpatrick, 2014; Pavulans et al., 2012), maladaptive coping strategies (Cavalcante & Minay, 2015; Everall et al., 2006; Ghio et al., 2011; Kizza et al., 2012), a lack of self-worth, self-hatred, and feelings of failure (Benson et al., 2016; Chung at al., 2015; Elliott-Groves, 2018; Everall et al., 2006; Orri et al., 2014; Rivers et al., 2018; Wiklander et al., 2003), a lack of trust in others,

loneliness and interpersonal isolation (Akotia et al., 2019; Benson et al., 2016; Bonnewyn et al., 2014; Chung at al., 2015; Gutierrez et al., 2015; Vatne & Naden, 2012), interpersonal challenges, losses and conflict (Bonnewyn et al., 2014; Cavalcante & Minayo, 2015; Ghio et al., 2011; Orri et al., 2014), suicidal exhaustion (Benson et al., 2016; Bonnewyn et al., 2014; Pavulans et al., 2012; Vatne & Naden, 2012), suicide as a way to end the pain (Bonnewyn et al., 2014; Everall et al., 2006; Ghio et al., 2011), hopelessness and a loss of control over life (Crocker et al., 2006; Everall et al., 2006; Fitzpatrick, 2014). Neither our review nor these primary papers were comparative gender studies. However, we speculate that the underlying psychology of men and women who are suicidal may potentially be similar. Denial, disconnection, and dysregulation of emotions, self and interpersonal connections could potentially underpin an element of female suicide risk too. However, we suggest that men may potentially be at a higher baseline suicide risk because of masculine norms that may mean more men than women culturally inherit harms in these core domains. For example, scholars suggest that gender differences in the experience of emotions may be primarily influenced by social norms that prescribe gender-specific emotional behaviour (Burn, 1996; Danielsson & Johansson, 2005; Wester et al., 2002). Chaplin and Aldao's (2013) meta-analysis of gender differences in children's emotional expression found no gender differences in infancy, with small but significant distinctions beginning to appear from toddler age onwards. Research suggests that boys show reduced verbal expression compared to girls by age two, and less facial emotional expression by age six (Levant, 2006). Many men go on to be socialised in norms advocating masculine stoicism and the suppression of emotions and vulnerability (Anderson, 2009; Kingerlee et al., 2014; Levant, 1996). A meta-analysis of empirical gender differences in alexithymia found significant differences in non-clinical populations, with men displaying higher levels of alexithymia than women (Levant et al., 2009). Norms of male emotional suppression may impact men's interpersonal connections. Karakis and Levant's (2012) study exploring the impact of male normative alexithymia on relationships showed that it correlated negatively with relationship satisfaction, communication quality and positively with fear of intimacy. Other research has shown a link between alexithymia and interpersonal problems and that some men can struggle to express attachment (Frye-Cox & Hesse, 2013; Levant et al., 2009; Vanheule et al., 2007; Zarei & Besharat, 2010). In certain cultures, new norms are evolving for men to take on more active and nurturing roles within interpersonal dynamics and some men may perceive themselves as lacking the emotional skills to do so effectively and lacking a psychologically safe space in which to learn them (Levant et al., 2006; Samaritans, 2012). Some men could read

relationship challenges and conflict as symbolising a masculine failure to care, protect, provide and/or satisfy significant others. Similarly, scholars have hypothesised that men have historically experienced stringent norms regarding male success that could leave men particularly vulnerable to feelings of failure, especially concerning financial and work-related stress (Coleman et al., 2011; Scourfield, 2005; Swami et al., 2008). Norms that encourage men to be absent economic providers and that emphasise male achievement over connectedness may isolate some men from the protective value of intimate connections (Levant, 1996; Swami et al., 2008).

We suggest cultural harms to men's relationships with their emotions, self and others, coupled with a potential preference in men to use lethal means, like hanging and firearms, could explain some of the gender paradox in suicide. The role of masculine norms may also be relevant to men's higher use of lethal means (Möller-Leimkühler, 2003). Canetto and Sakinofsky (1998) suggest hegemonic ideals of masculinity may create a cultural script that suggests that suicidal behaviour is courageous, decisive and masculine. The use of lethal means may represent men reclaiming masculine control over their distress and ensuring that their suicide attempt results in death, i.e., "success" rather than survival i.e., "failure", and potentially having to face the world with their pain and struggles exposed. Swami et al. (2008) also suggest that gender may inform men and women's familiarity with different suicide methods. For example, men are more likely to own, store and understand how to operate a firearm (Swami et al., 2008). It is important to note that in our findings, other methods more commonly associated with women, such as cutting and overdoses, were also cited in male deaths and attempts (Byng et al., 2015; Biong et al., 2007; Cleary, 2005). We encourage qualitative researchers, in future studies, to reflect on how the gender paradox may or may not be evident or explained in their data whilst also acknowledging the diverse spectrum of masculine and feminine identities (Scourfield, 2005).

3.5.6 Theoretical Implications

In this section we review the theoretical implications of our findings and make seven recommendations for future exploration in relation to male suicide, summarised in Table 3.3.

Table 3.3 *Recommendations for male suicide theoretical exploration*

Psychological Phenomenon	Recommendations
Pain	1. Explore theoretically delineating psychological pain from physical pain to understand their specific relationship in men who are suicidal.
Culture	2. Explore integrating culture into theories of suicide and the impact of cultural norms on men's relationship with psychological phenomena identified as critical to suicide risk.
Emotions	3. Explore integrating emotional regulation into theories of suicide and how cultural norms impact how men learn to connect with and regulate their emotions and psychological pain.
Self	4. Explore the integration of feelings of failure in theories of suicide and how cultural norms of male success and social value impact men's relationship with self.
Connections with Others	5. Explore how cultural norms impact on men's interpersonal needs, male loneliness and isolation, and how men build intimacy and meaningful connection.
Childhood Challenges	6. Explore theoretically integrating childhood challenges into theories of suicide and how they may impact men's exposure to, and tools to regulate, psychological pain and how these processes may interact with cultural norms.
Evolution	7. Explore from an evolutionary perspective the importance of psychological phenomena identified as potentially critical to male suicide.

3.5.6.1 Theories of Suicide and Psychological Pain

Our data support the theoretical centrality of high exposure and poor regulation of psychological pain to male suicide (Shneidman, 1993; Soper, 2018). It may be theoretically important for future research to explore delineating the impact of psychological pain on suicide risk from physical pain. Ideation-to-action theories of suicide posit that increased physical pain tolerance may characterise people who attempt suicide (Joiner, 2005; Klonsky & May, 2015; O'Connor, 2001). The assumption is that exposure to events that increase a person's physical pain tolerance may increase their capability to carry out suicidal behaviours. If this is correct, men who attempt suicide should have a higher physical pain tolerance than other men. Our data did not provide insight into physical pain experiences. However, the potential presence of heightened psychological pain was apparent across studies. As such, there may exist a pain paradox whereby men who are suicidal are desensitised to physical pain but potentially more sensitive to psychological pain. Recent studies with non-suicidal populations suggest a potential positive correlation between physical pain and social pain, with people more sensitive to physical pain more sensitive to

social distress (Yao et al., 2020). It is possible men who are suicidal may not follow this pattern.

3.5.6.2 Theories of Suicide and Cultural Norms

The role of culture is not explicitly addressed in leading suicide theories. Findings from this review suggest its theoretical significance. Cultural norms relating to acceptable and appropriate behaviour for men within the domains of emotions, self and connections with others were potentially important in shaping some men's exposure to and regulation of psychological pain. Integrating an understanding of how cultural norms may impact a man's connection and relationship with psychological phenomena identified as critical to theories of suicide, could help expand our understanding of certain men's risk exposure.

3.5.6.3 Theories of Suicide and Emotional Regulation

Specific emotional states, such as hopelessness (Klonsky & May, 2015; Joiner, 2005; O'Connor, 2011) and defeat and entrapment (O'Connor, 2011), are integrated within particular theories of suicide. Our findings support the potential theoretical importance of these emotional states. In addition, our data suggest that it may be valuable to integrate emotional regulation as a broader concept into theories of male suicide. Emotional regulation is central to Linehan's (1993) theoretical work developing therapeutic treatments for people with borderline personality disorder, and poor distress tolerance is referenced in Rudd's (2006) Fluid Vulnerability Model. Otherwise, emotional regulation lacks prominence in most theories of suicide. This omission seems incongruous considering the widespread acceptance of psychological pain to understanding suicide. Psychological pain is, in part, emotional pain and suicide is often driven by emotions that, in the moment of suicidal crisis, feel like they cannot be regulated in a life-orientated way. As such, suicide is often a deeply emotional act. A person's ability to regulate their emotions is intertwined with their ability to manage their psychological pain effectively. Integrating a concept of emotional regulation explicitly into theories of suicide could help inform risk. Any theoretical integration of emotional regulation will also need to consider the relationship between emotions and cultural norms. Understanding norms for male emotionality in a specific location and how men are culturally encouraged to regulate their emotions, cope with psychological pain and seek to relieve it, could help inform aspects of male suicide risk.

3.5.6.4 Theories of Suicide and Feelings Towards Self

Our review suggests that the presence of aversive self-awareness may play a central role in male suicide risk. This finding has strong theoretical accordance with Baumeister's 'Escape from Self' theory, which describes suicide as driven by the desire to escape negative self-aversion. Perceived burdensomeness is also a core component of Joiner's 'Interpersonal Theory of Suicide' (2005). This burdensomeness is related to 1) a belief that the self is flawed and a burden to others and 2) aversive self-hatred. Our data suggest strong support for potential awareness of a failed/flawed self in the mind's of men who are suicidal, but this pain was rarely articulated in relation to being a burden on others though we acknowledge that these constructs are deeply intertwined. However, it may be important for professionals and loved ones to be sensitive to male narratives of self that are oriented towards declarations of failure. It is also worth noting that some men described understanding the pain their death would cause loved ones, which suggests they understand themselves to be valuable and meaningful to others – not solely a burden (Pavulans et al., 2012; Vatne & Naden, 2016). Some men who are suicidal seemed conscient of the traumatic need to burden loved ones with the pain of their death because the perceived burden to themselves of enduring their psychological pain was too much to bear.

Similarly, while many men in our data appeared consumed by feelings of failure, we would caution against characterising these feelings as those solely of self-hatred. Self-hate was referenced in some narratives within our data (Ferlatte et al., 2019; Strike et al., 2006; Tryggvadottir et al., 2019) but the self was also referenced in terms of feelings of sorrow and grief (Akotia et al., 2019; Bell et al., 2010; Oliffe et al., 2019). The language of self-hate has the potential to make the 'self' the enemy in a suicidal crisis rather than, for example, the self being a victim of structural circumstances, oppressive cultural expectations, or other people's abuse. Perceiving yourself to be a failure can provoke many emotions of which hatred may be an aspect. As Shneidman notes, "suicide can be other than homicide; the principle emotional state can be other than rage (p. 248, 1998).

Again, understanding the theoretical relationship between self and suicide will require taking a cultural perspective into account. If we accept that feelings of failure may be theoretically relevant to male suicidal behaviours, we must also explore cultural contexts. Different cultures will have different ideals, expectations and demands regarding what constitutes a

man of social value (Markus & Kitayama, 2010). Understanding male suicide risk may require exploring cultural expectations for male success and failure in specific locations, the resources individual men have to meet these markers and what sort of subjective wellbeing achieving them yields.

3.5.6.5 Theories of Suicide and Connections With Others

Our findings support Joiner's theoretical assertation of the centrality of 'thwarted belongingness' to suicidal behaviours. Joiner et al. understand thwarted belongingness to consist of two dimensions "loneliness and the absence of reciprocally caring relationship" (p. 582, Van Orden et al., 2010). Distinctions between these two components are potentially crucial. Our data presented narratives of men who appeared visibly socially isolated (lacked caring relationships), as well as of men who appeared enmeshed in social relations but who perceived themselves to be unable to be meaningfully known within those dynamics (lonely). The only additional theoretical implication is the integration of a cultural perspective. Understanding the cultural permissions offered to men with regards the level of connection and intimacy within friendships, family, and romantic dynamics could be important to understanding male suicide risk.

3.5.6.6 Theories of Suicide and Childhood Adversity

Both Joiner (2005) and O'Connor (2011) reference childhood adversity in their ideation-to-action models of suicide. Our data suggest this may be important as childhood experiences appeared to expose some men who are suicidal to significant psychological pain and potentially contributed to emotional dysregulation and aversive feelings of self.

3.5.6.7 Theories of Suicide and Evolution

Theoretical explorations of evolutionary pressures for effective regulation in specific domains could help elucidate why the dysregulation of certain phenomena could lead to suicide. This review suggests that dysregulation of emotions, self and connections with others could elevate men's suicide risk. Future theoretical work to explore evolutionary explanations for the importance of these domains to human well-being may help advance our understanding of why suicide may be activated in response to them being thwarted. For example, emotions are

understood to be critical to human life (Adolphs & Anderson, 2018). Emotions help facilitate communication and social bonding, they are "meaning-making tools" that help us understand and explain our experiences and drive our behaviours (p.139, Barrett, 2017). Our "emotional coping strategies have evolved over some six million years of hominid existence" (p. 110, Langs, 1996). The cultural suppression of aspects of men's emotions potentially undermines millions of years of evolution and may deny some men access to fundamental parts of their humanity and a functioning relationship with a core coping/regulatory system. Similarly, a positive self-concept helps imbue our lives with the agency to drive and direct behaviour (Stevens, 1996). Farberow asserts that to function in modern cultures, people need to be able to like or at least tolerate themselves (2004). From an evolutionary perspective, stringent cultural demands around male success may leave some men vulnerable to developing dysregulated feelings of self that may undermine another core aspect of regulation. Lastly, as one of the most social species in existence, successful social bonds and belonging are critical to human survival (Baumeister & Leary, 1995; Eagleman, 2016; Humphrey, 2007; Perry 2014; Wilson, 2019). Other people help regulate our physiology and positive social bonds provide safety and a feeling of psychological well-being (Barrett, 2017). This evolutionary context may help explain why actual or perceived ruptures in a person's ability to create and/or maintain meaningful connections have been linked with psychological distress and multiple health issues (Smith & Weihs, 2019). Primates raised in social isolation have shown self-harming behaviours such as self-biting (de Catanzao, 1981). Norms that suppress men's interpersonal needs may limit some men's ability to fulfil an evolutionary drive for social connection, belonging and safety.

In summary, our findings illustrate how multiple theoretical explorations help us to understand male risk specifically.

3.5.7 Recommendations for Male Suicide

Finfgeld (2003) advocates that the ultimate value of qualitative meta-synthesis lies in its utility to "improve clinical practice, research, and health care policies" (p. 903). To that end, we make the following recommendations for male suicide research and interventions based on our findings. This list is by no means exhaustive. Our recommendations are based on qualitative source papers and will not be representative of every man's experience. We do not

know how many men in our sample went on to die by suicide irrespective of potential interventions. Recovery work needs to consider cultural contexts with different demographics of men i.e., rural men, elderly men, sexual minority men, potentially requiring different types of support (Crocker, 2006; Lee & Owens, 2022; Player et al., 2015). Many of these recommendations need to be fully scoped out and evaluated before we can claim that we have established science-based interventions that improve suicide recovery.

3.5.7.1 Interventions for At-Risk Individuals

3.5.7.1.1 Psychological Targets for Interventions.

Although the evidence base for effective interventions for suicidal people has grown, it is still not sufficient (Franklin et al., 2017; O'Connor & Nock, 2014) especially with respect of treating or supporting the recovery of men who are suicidal. This dearth was also the case with our data. Of the codes in our review 77% related to risk factors and only 23% to recovery. Papers rarely revealed the specificity of any interventions i.e., therapeutic modes, time frames, and length of interventions. Instead, the value of our findings comes from broad insights into the general psychological shifts that participants described as potentially helping aid suicidal relief which need significant scientific evaluation to determine if they are useful. Our findings support broad hypotheses that interventions which target helping men to 1) regulate their psychological pain, 2) regulate their emotions, 3) revise aversive concepts of self, especially with regards to feelings of masculine failure and shame, and 4) improve interpersonal relating and meaningful connection, could have utility. These domains can be targeted in different ways, i.e., through individual therapy, peer support groups, and at different levels, i.e., clinical, community, policy, and public health campaigns. These claims need to be evidenced and we need to understand how interventions can be best delivered, over what time period, and using what intervention/therapeutic models, potentially in combination.

3.5.7.1.2 Post-Attempt

In our data the immediate aftermath of a suicide attempt was highlighted as a time of high emotional volatility though there was scant evidence for effective interventions. Our data suggest that following an attempt, many men may remain on the cusp of suicidal action. This may indicate that men's psychological resources are too depleted to cope with intensive

therapeutic work during this period. Priority should potentially be given to safety and stability with more intensive therapeutic work to resolve underlying drivers of suicidal behaviours coming later in recovery journeys. A recent meta-analysis (Nuij et al., 2021) and cohort comparison study (Stanley et al., 2018), have shown that safety planning interventions which prioritise coping strategies and social contact post a suicide attempt have utility. Suicide interventions and clinical practitioners should be mindful of the tension imbued in suicide recovery as individuals may oscillate between the suicidal impulse to escape the pain of the present while simultaneously trying to build hope for a better future (Baumeister, 1990; Vatne & Naden 2014).

3.5.7.1.3 Therapeutic Support

Our findings suggest that supporting men to regulate their psychological pain is potentially important (Ferlatte et al., 2019; Gajwani et al., 2018; Mackenzie et al., 2018). This work often requires bespoke therapeutic support (Shneidman, 1998). A recent study of intervention preferences for men in outpatient care found that most men wanted long-term, individual psychotherapy (Kealy et al., 2020). The financial cost of private therapy and long waiting lists in public systems, means there may also be utility in exploring self-guided therapeutic tools for men who cannot afford/access therapy. A meta-analysis of digital psychological self-help interventions show they have promising value (Torok et al., 2020). It is important to be mindful when assessing the potential utility of therapeutic work that without interventions in other domains - especially those relating to structural pressures - the impact of therapy may be short-lived or limited (Chandler, 2021).

3.5.7.1.4 Multi-level Interventions

Recovery may require a network of interventions delivered by different services (Kizza et al., 2012; Pavulans et al., 2012; Ribeiro et al., 2016; Sher, 2020). A gay man in River (2018) described CBT as relatively helpful but it was only when joining a community group for gay men that he perceived peer support enabled him to address the deep feelings of shame and isolation driving his despair. Some men may need support for their alcohol dependency alongside therapeutic support so that their emotional pain when sober is bearable (Rivlin et al., 2013), other men may need additional vocational training (Ribeiro et al., 2016). Multi-level interventions that tackle psychological and structural issues in conjunction may be a

valuable line of research and service development (Struszczyk et al., 2019). A pilot randomized trial of the “HOPE” (help for people with money, employment or housing problems) service, a brief psychosocial intervention that provides both mental health and financial support to people presenting at hospitals in acute distress, has shown feasibility (Barnes et al., 2018). Similarly, a two-year multi-modal intervention that targeted four different sites, including individuals in distress, their families, primary care staff, and public health campaigns, showed a 24% reduction in suicide deaths/attempts compared to a control region and baseline year (Hegerl et al., 2013).

3.5.7.1.2 Clinical Interventions

3.5.7.1.2.1 Assessing Risk

The findings in this review add to existing evidence that assessing suicide risk is highly complex (Carter et al., 2017; Glenn & Nock, 2014; Large & Ryan, 2014; Mackenzie et al., 2018; Pisani et al., 2016; Scourfield et al., 2012). The diverse stories in our data support suggestions that suicide does not appear to follow a linear path which makes identifying and developing reliable risk factors, profiles and assessments challenging (Zortea et al., 2020). A systematic review and meta-analysis of risk scales found that no scale could predict risk with meaningful accuracy (Carter et al., 2017). Findings from our review show some support for calls to move away from standard risk assessments (Mackenzie et al., 2018; Pisani et al., 2016; Zortea et al., 2020). Scholars have suggested that clinicians instead need to ground their assessments in a better understanding of "the psychosocial factors associated" with suicide risk (p. 9, Zortea et al., 2020). Significantly more resources are potentially required to allow mental health systems the time to hold these deeper assessment conversations and provide clinicians with sufficient training in male psychosocial risk factors (Carter et al., 2017; Pisani et al., 2016; Seidler et al., 2019). Findings from this review suggest that narratives which indicate signs of denial, disconnection and dysregulation of emotions, self and interpersonal connections could potentially indicate elevated suicide risk and also present specific modifiable, psychological targets for tailored interventions. In this way risk assessment moves away from suicide prediction to synthesising “information that facilitates prevention” (p. 625, Pisani et al., 2016). Much more research is needed to test these assumptions and develop evidence-based tools to guide assessments. We note the emotional burden placed on professionals currently responsible for making suicide risk assessments

with tools that are potentially inadequate and that require more research to improve and evidence that they work.

3.5.7.1.2.2 Gender-Sensitive Professionals

Given the association between shame and suicide (Rice et al., 2020), it is potentially important that masculinity is not framed as toxic or pathological by professionals so men who are suicidal do not further internalise negative notions of self (Levant, 1992; Struszczyk et al., 2019). Seagar and Barry (2014) argue that men who are struggling will respond better in environments where "a positive, inclusive, empathic and respectful approach to men and boys is offered" (p.119). Our findings support suggestions by Mahalik et al. (2012) that modules on male socialisation be embedded in clinical training programs, for example understanding male distress presentations, and how masculine norms may contribute to men's psychological pain and the behaviour of men encountered in services (Lester et al., 2014; Seidler et al., 2019). Norms of emotional suppression - to conceal or downplay struggles - may cause some men to have more difficulties, or initial hesitancy, in describing their interior worlds (Levant et al., 2009; Vanheule et al., 2007). Some men may also present with physical symptoms rather than psychological ones. Suicide can be, in part, the manifestation of a coping crisis (Vatne & Naden, 2014). Given masculine norms around male autonomy, control and success, clinicians should potentially be compassionate and alert towards what surviving an attempt or revealing thoughts of suicide may mean for some men who may have been conditioned for years to cope by denying their struggles. Some men's sensitivity to autonomy and needing to trust and respect practitioners may all impact male distress presentations and responses to clinicians. Seidler et al. (2019) make further important recommendations around clinicians' assessing their own gender-based views and potential biases. Services need to become gender-sensitive, though Seidler et al. (2018) warn this does not mean adopting a homogenous approach to male care. Every man who is suicidal has his own history; his own culturally informed schemas of self, emotions, and interpersonal relating; his own learned coping strategies and safety-seeking behaviours; as well as embodying his own intersectionality of identities across multiple dimensions such as race, sexuality, disability, education, socio-economic status, caregiving responsibilities, interpersonal connections etc., all of which will potentially contribute to the level of psychological pain in his life.

3.5.7.1.2.3 Men's Help-Seeking Attitudes and Experiences

Help-seeking was rejected by some participants as a perceived 'weakness' (Cleary, 2012; Kunde et al., 2018; Player et al., 2015). This is in keeping with theories that suggest by ignoring their wellbeing, some men perform a vision of masculinity that demonstrates strength and independence (Courtenay, 2000). The help-seeking behaviour of men is, however, complex and nuanced. Some men reported that their self-esteem was so decimated they did not consider themselves worthy of the attention of service providers (Rasmussen et al., 2014; Strike et al., 2006). The medical model appeared to actively deter some men, and if you don't think the "help" will help, you are not going to necessarily seek it (River, 2018). Some men suggested that they did not understand the utility of talking about problems, potentially reflecting cultural messages they may have received that men do not need to discuss their struggles (Cleary, 2012). It is also important to acknowledge that there are still communities where admitting distress may come at significant social cost for some men and that simplistic messages that problematise men not talking or seeking help may undermine complex cultural realities (Chandler, 2021). If men receive cultural messages that suggest they need to be strong, independent and competent then feeling unable to cope independently with distress may add to feelings of failure and shame (Rice et al., 2020). In this light, denying distress may become a logical, if ultimately dangerous, coping strategy within the confines of cultural norms of masculinity. Some men may also be vulnerable to accruing more distress than they can cope with given the potentially limited cultural education societies offer some men in understanding and regulating their emotions.

Alongside continued work to understand men's barriers to accessing support, our data also suggests it is also important to problematise the help available for men. In this review we found more evidence of men seeking help but describing bad experiences. This review highlights the need previously identified by researchers to examine how health services can better tailor provision to meet men's needs (Seidler et al., 2018; Seidler et al., 2019; Seidler et al., 2020; Tang et al, 2022). It may be important to consider how current mental health practices interact and potentially exacerbate sources of psychological pain in men who are suicidal. For men who may be harbouring shameful feelings of failure and who have been socialised not to disclose their pain, sitting down in a doctor's chair and speaking their pain aloud to another person, potentially for the first time, could represent a moment of profound vulnerability. In this context, time-pressured and medically focused encounters may be highly

alienating. Similarly, men with high levels of hopelessness and/or entrapment, may be deterred by systems with long waiting lists. Seeking help also requires persistence (Ferlatte et al., 2019) and public campaigns may need to consider how to realistically prepare men for help-seeking journeys that may require resilience and seeking support multiple times including navigating potentially negative experiences.

3.5.7.1.3 Non-Clinical Interventions

3.5.7.1.3.1 Significant Others

Given the importance of interpersonal connection theoretically to suicide (Joiner, 2005) significant others may be a vital recovery resource for men (Player, 2015; Vatne & Naden, 2016). In our data, affirmations from loved ones and lay-led interventions were described as sometimes more powerful and welcome than medical/counsellor interventions (Ferlatte et al., 2019; Owens et al., 2005; Player et al., 2015). Significant others can be on the frontline of a loved one's suicidal crisis and placed under enormous emotional pressure (Owens et al., 2011; Lascelles, 2021; Peters et al., 2013). Navigating dynamics with significant others post-attempt may be complicated (Jordan et al., 2012; Tzeng, 2001). Suicide attempts may strain relationships, and in some cases, historical tensions may have contributed to a man's suicidal crisis, or a man's dysregulated behaviour may have alienated him from others (Fogarty et al., 2018; Vatne et al., 2016). Working with loved ones in a therapeutic context to deal with historical pain could help defuse painful relations so these dynamics can have more abundant protective value (Ghio et al., 2011). RCT's of family interventions with suicidal adolescents have shown good results (Diamond et al., 2010; Pineda & Dadds, 2013). Families and friends are often closest to men in crisis and can potentially identify concerning shifts in behaviour (Fogarty et al., 2018). Mental health professionals may need to balance patient confidentiality with taking the concerns of loved ones seriously, especially if a man denies thoughts of suicide (Peters et al., 2013). Significant others could also potentially benefit from more rigorous guidance on the broad and diverse ways male suicide risk can manifest.

3.5.7.1.2 Community Interventions

Given some men's preference for support in non-clinical spaces, our review supports suggestions that male suicide prevention should also consider how to empower interventions led by laypeople and communities who may have more contact and credibility with some

men (Hagaman et al., 2018; Rasmussen et al., 2014; Stanley et al., 2009). Peer support has been cited as an important community resource for suicide prevention (Jordan et al., 2012; Mackenzie et al., 2018; Vatne et al., 2018). In our data, talking to other people who are suicidal did not carry the perceived stigma of contacting helplines (Jordan et al., 2012) or hold the power imbalances perceived in therapeutic dynamics (Ferlatte et al., 2019). Men also described finding volunteering healing (Ferlatte et al., 2019; Salway & Gesink, 2018), echoing Baumeister's (1990) assertion that activities which "submerge the self in a broader community may reduce suicidal tendencies" (p. 97). There is a growing movement of community organisations and work schemes to support men's mental health. Preliminary evaluations of 'DUDES Club', a community intervention for Indigenous men in Vancouver, Canada (Gross et al., 2016); a football based mental health support group in Middlesborough, UK (Dixon et al., 2019); the MATES program tackling suicide in the construction industry in Australia (Ross et al., 2019) and James's Place a clinically based community intervention for men who are suicidal in Liverpool, UK (Chopra et al., 2021) all provide potential promising evidence, though have yet to be tested in RCTs.

3.5.7.1.4 Universal Interventions

Universal interventions target whole populations rather than individuals most at risk (Turecki et al., 2019) and may be another important element – within a suite of interventions - to reach and support men more broadly.

3.5.7.1.4.1 Suicide Psychoeducation

Our data suggest that programs and campaigns to help lay people better understand masculine norms and male suicide risk, tools to ask about suicide, respond to suicide disclosures and deal with long term suicidal crises may have utility. Psychoeducation programmes that help support people to better regulate emotions, selfhood, interpersonal connections, and psychological pain could also be effective. Suicide prevention may also need to assume a cultural lens and potentially consider the risk and recovery factors unique to certain communities (Tzeng, 2001). In our data, Han and Oliffe (2015) described the need for bespoke campaigns to target the mental health stigma prevalent in parts of the Korean community living in the United States that may prevent help-seeking. Osafo et al. (2015) identified the need for advocacy campaigns to address community stigma toward suicide survivors in Ghana. Early-life interventions were also cited as potentially important to equip

young people with the tools and skills to manage their well-being and stop childhood harm from escalating over the life course (Creighton et al., 2017; Ferlatte et al., 2019). RCT's have shown reduced suicidal behaviours following school interventions (Zalsman et al., 2016).

3.5.7.1.4.2 Representations of Masculinity

Richer representations of masculinity in the public domain could also be beneficial, especially around honouring male emotionality, expansive male selfhoods, male interpersonal needs, normalising struggles, and highlighting potentially counterproductive coping strategies – such as excessive alcohol. As mentioned previously, we should potentially be mindful of the role of shame in suicide and take caution in how masculinity is being portrayed in the public domain. As Levant (1992) notes, this work "must walk a fine line intellectually" by "crediting men for what is valuable about masculinity on one hand, and helping men come to terms with what must be changed on the other" (p. 385). We have all been socialised in norms of masculinity and expectations for male behaviours, and we all potentially have a role to play in educating ourselves about how these internal schemas may be narrowing possibilities for men. While acknowledging the positive aspects of masculinity, and gender norm fluidity, it is also important to recognise how all genders may perpetuate rigid adherence to masculine norms identified as potentially harmful in this review. For example, our data suggest the importance of considering how cultural norms may impact the understandings and behaviours of loved ones, friends and health professionals in responding to a man in suicidal crisis (Cleary, 2005).

3.5.7.1.4.3 Representations of Suicide

A widely held view in suicidology is that 90% of people who die by suicide have a psychiatric diagnosis (Cavanagh et al., 2003). However, in our review, there was nominal reference to the role of mental illness as a suicide risk factor. In multiple studies, the lack of psychopathology was explicitly noted (Kizza et al., 2012; Meissner et al., 2017; Sweeney et al., 2015). Some bereaved participants felt that understanding suicide as related to mental illness was "wrong" and "misleading" (Rasmussen et al, 2018, p. 4). Some men were actively deterred from accessing professional support because of the medical-psychiatric model (River, 2018). Our data align with recommendations from previous research, that men's suicidal pain and potential individual pathology, needs to be understood in the context of the lived experiences, environments, socio-political contexts and cultures that may allow distress

to bloom and grow (Akotia et al., 2019; Button, 2016; Fitzpatrick et al., 2014; Kunde et al., 2018; Laubschler, 2003; Lee & Owens, 2002). While we acknowledge strong evidence for a shift away from a narrow bio-medical paradigm, further research is required to understand what this would look like in practice and evidence that it does indeed help reduce suicidal behaviours.

3.5.8 Future Research

More research is required to interrogate and validate our findings. We make 22 suggestions for this work in Table 3.4 alongside the following three key recommendations.

Table 3.4 *Recommendations for male suicide research, prevention, and intervention*

Target	Area	Recommendations
At-Risk Men	Gender Paradox	1. Investigate the gender paradox in suicidal behaviours considering potential biological, psychological, and sociocultural factors that may differentiate male suicide behaviour from female.
At-Risk Men	Relationship with Emotions	2. Investigate the relationship between men's emotions and suicide risk, including: 1) how men who are suicidal understand, regulate and express their emotions and psychological pain; 2) what dimensions of male emotional regulation and male alexithymia may be relevant to suicidal behaviours; and 3) the relationship between substance use, alexithymia and suicide risk.
At-Risk Men	Relationship with Self	3. Investigate the relationship between masculine norms, feelings of failure and male suicide including: 1) what do men who are suicidal invest their self-esteem in and measure their selfhood against; 2) how do men who are suicidal regulate perceived failures; 3) what is the role of self-esteem, control, agency, and purpose in male suicide risk and recovery; and 4) how to effectively support men who are suicidal to repair aversive self-concepts.
At-Risk Men	Relationships with Others	4. Investigate how men's needs for connection and belonging are being met, or not, in contemporary societies, including: 1) male loneliness; 2) what meaningful connection means for men who are suicidal and the challenges they face in creating this; and 3) interventions to potentially support men who are suicidal to build skills for interpersonal relating - potential targets could include help to manage interpersonal stressors and skills for building intimacy.
At-Risk Men	Understanding the Psychobiology of Psychological Pain	5. Understand the psychobiology of psychological pain, including: 1) the relationship between psychological pain and other biological mechanisms such as neural and neuroendocrine activity, immune factors, and nervous system regulation; 2) potential biomarkers that could indicate heightened psychological distress that could be assessed clinically; 3) the relationship between psychological pain and factors such as diet, inflammation, brain-gut axis, sleep patterns, stress regulation, memory and cognition patterns; and 4) psychobiological interventions that could help men regulate psychological pain.
At-Risk Men	Help-Seeking	6. Explore the key barriers for different demographics of men to seeking help and effective messages and interventions to counter these.
At-Risk Men	Ideation vs Attempt	7. Investigate: 1) the contents, triggers and temporal dynamic of men's suicidal ideation; and 2) what potentially triggers a shift from thinking about suicide to planning a suicide and making an attempt.

At-Risk Men	Recovery	8. Explore what 'recovery' means for men who are suicidal and how men who are suicidal establish purpose and a connection to life. 9. Understand what areas of life men who are suicidal want help with and the skills they want to build.
At-Risk Men	Post-Attempt	10. Investigate: 1) how men cope in the immediate aftermath of a suicide attempt; 2) men's emergency admission and discharge experiences; and 3) evidence what immediate interventions are most effective for men and how these could be integrated with longer-term support.
Services	Therapy	11. Identify the most effective psychological targets for male-focused therapeutic interventions, including exploring psychological interventions which target helping men to: 1) regulate psychological pain; 2) regulate emotions; 3) revise aversive concepts of self, especially with regards to feelings of masculine failure and shame; and 4) improve interpersonal relating and meaningful connection. 12. Explore effective interventions for men who cannot afford/access therapy.
Services	Service Design	13. Explore the barriers men experience in accessing effective support and how interventions can be more effectively tailored to meet the needs of different demographics of men. 14. Explore how different services can work together better (i.e., how can the criminal justice system work with mental health care?) and multi-agency interventions i.e., structural support as well as psychological.
Services	Health Professionals	15. Explore training for professionals in cultural norms of masculinity and male suicide risk and recovery factors. 16. Explore tools to help professionals address their own gender bias and increase positive understandings of masculinity.
Services	Clinical Assessment	17. Explore moving away from risk assessment and towards developing potential risk profiles built on potential risk markers relating to denial, disconnection and dysregulation in self, emotions, interpersonal connections, and psychological pain.
Significant Others	Significant Others	18. Explore the role of significant others in supporting men in suicidal crisis, including: 1) how suicide disclosures are communicated, received and responded to by significant others; 2) mental health challenges for carers of men who are suicidal: 3) potential support to help significant others cope with, and support, a loved one in suicidal crises; 4) psychoeducation for significant others on male suicide risk and recovery factors; 5) working therapeutically with families' post-attempt; and 6) how the 'insider' knowledge that significant others can provide on a man's state of mind may be utilised by mental health professionals to keep men safe whilst respecting a man's dignity and autonomy.
Community	Community Support	19. Explore community interventions, including: 1) understand and evidence effective interventions; 2) identify effective community gatekeepers to support men at risk; and 3) explore volunteering opportunities for men who are suicidal.

Population	Representations of Masculinity	20. Explore norms of masculinity, including: 1) contemporary construction of masculine norms in different cultural settings 2) how men who are suicidal develop and form their ideas of masculinity, particularly those relating to understandings of emotions, self, interpersonal connections and psychological pain; 3) how norms are challenged and/or reinforced by significant others, communities and institutions; 4) how masculine norms can be operationalised to help protect men from suicide; and 5) richer and more inclusive representations of masculinity in the public domain particularly around men's emotions and interpersonal needs, expansive male selfhoods and destigmatising struggles.
Population	Representations of Suicide	21. Understand social representations of the biomedical model, mental illness, and suicide, including: 1) how men understand the causes of their suicidal pain and behaviour; 2) how to effectively communicate about suicidal pain in a way that elicits support-seeking rather than shutting it down; and 3) transfer findings into tangible changes to be tested in public health campaigns, clinical services, risk assessments, and interventions.
Population	Psychoeducation	22. Explore psychoeducation programmes that can help support people to: 1) better regulate emotions, selfhood, interpersonal connections, and psychological pain: 2) better understand cultural norms of masculinity and male suicide risk and recovery factors: and 3) have tools to ask about suicide and respond to suicide disclosures.

3.5.8.1 Researching Interactions

Our findings support previous calls for suicide research to focus on risk factor interaction (Franklin et al., 2017; Glenn et al., 2017; Glenn & Nock, 2014; Mackenzie et al., 2018; O'Connor, & Nock, 2014; Scourfield et al., 2012). Studying discrete risk factors stripped of context and stripped of their interaction does not tell us much. We believe that the qualitative work in this review provides significant value in terms of generating theories of risk and recovery factor interaction rooted in the lived reality of the phenomena, that can be tested quantitatively, temporally and in interaction using different methodologies including network analysis models (de Beurs, 2017) and ecological momentary assessment (Sedano-Capdevila et al., 2021). This work needs to be tailored to different demographics i.e., prisoners, gay men, retired men, First Nations men (Franklin et al., 2017; O'Connor & Nock, 2014). This work could help develop more effective risk assessment tools that identify key risk factors in interaction and bring us closer to understanding potential ideation/attempt profiles better (Albanese et al., 2019; Glenn et al., 2017).

3.5.8.2 Research Collaborations

Many methodologies and disciplines are critical to illuminating our understanding of suicide (Glenn et al., 2017; Leenaars, 1996; Shneidman, 1993). In our findings only a psychological lens based on qualitative methods has been applied to the multi-faceted behaviour of male suicide. Factors beyond the scope of this review such as neuroendocrinology and immunology will be active in male suicide (Fazel & Runeson, 2020; Sher, 2017). Multi-disciplinary research teams could explore findings proposed here to test their relevancy and implications across different domains pertinent to suicide.

3.5.8.3 Understanding Contemporary Norms

Gender theorists have proposed that the construction of masculinity is rooted in claiming power over others and avoiding feminine and/or homosexual associations (Anderson, 2009; Connell & Messerschmidt, 2005; Courtenay, 2000; Di Bianca & Mahalik, 2022; Levant, 1992). In our review homophobia was a potentially violent force in the narratives of queer men (Ferlatte et al., 2019; McAndrew & Warne, 2010) and fear of the feminine was referenced in a few studies (Cleary, 2012; Kizza et al., 2012). Otherwise, our data, which (as

far as was documented) was seemingly predominantly drawn from a mainly cis-gendered, heterosexual, white sample, was largely silent on the role of power and feminine/homosexual avoidance. This lack of evidence, compared to other findings, highlights the strong need for future research to investigate the construction of contemporary masculine norms. In certain places, masculinity may not be defined in contrast to femininity or homosexuality, though it's also possible that these ideas are still widespread but have become so deeply internalised that they are not consciously recognised or are considered too taboo to openly discuss. In their review of measurements of masculine ideology, Thompson and Bennett (2015) question the utility of targeting male attitudes towards dominance and femininity-avoidance citing that many participants now disagree with these. They argue that the "masculinities men live by have dramatically changed as both the hegemony of heteronormative social worlds fades and the legitimacy of sexist gender relations is questioned" (p. 10). We recommend more cultural-specific research to interrogate the construction of contemporary masculine norms especially those most related to suicide risk (Wong et al., 2017). For example, findings from a study with students in the United States, suggest that conformity to self-reliance and emotional control norms were more of a barrier to help-seeking than violence, power over women, and heterosexual self-presentations (McDermott et al., 2018).

3.5.9 Limitations

3.5.9.1 Study Participants

Our findings are limited by what participants in the data knew about themselves, were prepared to disclose, and/or the accuracy with which events were recalled (Chung et al, 2015). Potential important factors may not have surfaced because participants did not feel safe sharing them or were still in denial about them. This may be particularly true concerning topics with a high social taboo factor, such as sexuality, abuse, violence, trauma etc., especially if male norms not to disclose vulnerabilities or struggles, are factored in.

3.5.9.2 Researchers

Both the synthesis provided in this review and the studies analysed have been filtered through the subjective biases of researchers. As mentioned, the primary author of this paper has a closeness to the material through lived experience which may have shaped their interpretation

of data. To mitigate this, we followed a systematic methodology and our findings have also been triangulated via multiple authors and reviewers. However, it is still important for readers to remember our findings represent "one empirically driven interpretation of the data among other possible interpretations that also might have value" (Levitt et al., 2016, p. 822).

3.5.9.3 Key Demographics Missing

A major limitation of the literature is the lack of insight it can provide for the unique challenges and needs of men from different racial demographics, trans-men, men with disabilities or low- and middle- income contexts. As noted by one reviewer, our inclusion of 'men' in the search criteria may have led to the omission of trans studies from our results. We re-ran our search strategy, exchanging search terms related to 'men' for 'trans' and found three qualitative studies that highlighted issues of thwarted belongingness, suicide as a pain-ending strategy and the importance of social connections as a protective factor in trans suicide (Bailey et al., 2014; Hunt et al., 2020; Moody et al., 2015). We also excluded grey literature and dissertations which may contain additional important insights.

3.5.9.4 Lack of Specificity and Utility in Predicting Male Suicide

Our findings are broad and do not necessarily offer insight into how to uniquely predict suicide in men over other psychopathologies. Many of our findings would be risk and recovery factors for other phenomena such as depression or addiction. The lack of specificity and sensitivity in our findings are the same issues encountered in other quantitative reviews of suicide and male suicide (Franklin et al., 2016; Hunt et al., 2017; Richardson et al., 2021). Alongside work focused on identifying unique predictors of suicide, we believe there is utility in taking a holistic view of men's psychological pain and accepting that this pain can manifest in many ways. Given that over the last 50 years of research our ability to predict suicide remains no better than chance (Franklin et al., 2017), a more concerted effort to situate suicide prevention in a broader context is potentially required. By tackling distal contributors to men's suffering, we can potentially reduce suicide as well as other psychopathologies. Li et al.'s (2011) systematic review comparing interventions to tackle the distal risk factor of socio-economic deprivation against interventions to tackle the proximal risk factor of mental disorders had "similar population-level effects" (p. 608)"

3.6 Conclusion

Male suicide rates indicate that certain men struggle profoundly to access a life that can be well-lived (Connell & Messerschmidt, 2005). Our findings suggest suicide prevention may need to assume a gender-sensitive lens that exercises compassion towards how masculine norms may impact male psychological pain and how this distress is read and responded to (Seidler et al., 2019). While conversations about male privilege are gaining prominence in the public sphere it is important to acknowledge how some men's needs are not being met within our gendered worlds (Lee & Owens, 2002; New, 2001). Navigating a space within public discourse for an open and frank conversation about the male experience is critical. It is important to maintain a productive dialogue about the intersectionality of privilege and an understanding that it is not a "zero-sum quantity" (Coston & Kimmel, 2012, p. 98). People can be privileged in one domain and lack privilege in another. Without vilifying or pathologising masculinity, findings from this review suggest that deepening our understanding of certain masculine norms and how they may harm men could be critical to shaping effective male suicide prevention work. The future flourishing of a more gender-equitable world may depend, in part, on us collectively acknowledging and transforming these potential cultural harms.

Chapter 4 "Exploring psychosocial factors that distinguish men who have attempted suicide from men with thoughts of suicide and men who have never been suicidal. Findings from a global cross-sectional survey."

4.1 Abstract

Objective: Worldwide, more men die by suicide than women in virtually all countries. Yet, our understanding of the psychology of male suicide risk is poor. This study investigated whether measures relating to emotions and psychological pain, feelings towards self, and interpersonal connections are associated with suicidal history (suicide attempt group vs suicidal ideation group vs no suicidal history/control group).

Methods: 2,763 men participated in an online global survey assessing demographic characteristics and measures of suicidal history, feelings towards self, emotions/psychological pain, and social connection.

Results: Multinomial logistic regression analyses indicated that higher levels of loneliness and having a mental health diagnosis increased the odds of being in the suicidal ideation group compared to controls. Having a mental health diagnosis, and being non-heterosexual increased the odds of being in the suicide attempt group compared to controls. Finally, higher levels of financial strain, having a mental health diagnosis, being non-heterosexual, having more restrictive attitudes to emotional expression, and lower levels of mattering to others, increased the odds of suicide attempt group membership compared to suicidal ideation.

Limitations: Findings are limited by the cross-sectional, retrospective design, which prevents determining causality. Responses may be influenced by recall bias, self-report bias, and self-selection bias.

Conclusion: Results broadly suggest that the factors indicated by the 3 'D' Risk model (increased emotional/psychological pain, more negative feelings and thoughts about the self, and reduced connections with others) seem important to understanding the increased risk of suicidal thoughts and behaviours in men. Clinical implications include the importance of interventions that support men's emotional regulation and strengthen meaningful connections with others.

4.2 Introduction

Suicide is one of the most critical issues relating to men's health. Data suggest that approximately three-quarters of all suicide deaths worldwide are male (WHO, 2018). In the UK, men under 50 are more likely to kill themselves than die any other way (Mental Health Foundation, 2021). Within suicide research, work to understand suicide risk specifically in men, has been underfunded and under-researched (Bilsker & White, 2011; Bennett et al., 2023). As such, there are critical gaps in our understanding of why men are particularly vulnerable to dying by suicide (Richardson et al., 2021).

Various factors have been identified as potentially elevating men's risk. Men are less likely to seek help and more likely to use lethal means - such as firearms - and die on a first attempt (Jordan & McNieil, 2020; O'Donnell & Richardson, 2018). As mentioned previously, a recent systematic review of quantitative publications on male suicide risk identified 68 potential risk factors, with the strongest evidence pointing towards men who have a diagnosis of depression, are romantically unattached, and/or have substance abuse challenges (Richardson et al., 2021). This study highlights some of the problems facing the field. As the study authors note, many of the identified risk factors have limited utility because they do not help to distinguish between the multitudes of men who experience similar challenges but who are not suicidal. For example, millions of men are diagnosed with depression but do not kill themselves. Similarly, trying to develop prevention and intervention strategies to tackle the 68 identified risk factors creates a complicated context. To move the field forward, increasing our understanding of suicidal ideation and suicide attempts as separate (though interrelated) states of being is crucial (O'Connor & Nock, 2014; Pirkis, Burgess & Dunt, 2000). Understanding the psychosocial factors that may distinguish men who experience suicidal ideation from men who attempt suicide could support the provision of more targeted interventions to manage these different states and potentially save lives.

4.2.1 Suicidal Ideation Versus Suicide Attempts in Men

There has been limited research into the potentially different social and psychological characteristics of people who think about suicide distinct from people who attempt suicide. Previous non-gender-specific work has suggested people who attempt suicide may

experience higher rates of psychopathology and childhood adversity (Fergusson & Lynskey, 1995). Pirkis et al. (2000) found that people with a suicide attempt history are more likely to be unemployed and not married than those who are not suicidal, and unemployment was the only factor differentiating people who have made a suicide attempt from those who have thought about suicide but not acted on their ideation. Further empirical research to specifically explore potential psychosocial distinctions between men who think about suicide and men who attempt suicide is urgently needed. This work is particularly critical given the reported shorter suicidal process in men. Research suggests the time between a first communication about suicide and death is, on average, 12 months in men compared to 42 months in women (Neeleman et al., 2004), and men are also more likely to die on their first attempt (Jordan & McNieil, 2020).

Findings from Study 1, Chapter 3 – the meta-synthesis of 78 qualitative studies on male suicide - illuminated potential psychological pathways underpinning male suicide. Most of the studies in the synthesis (96%) suggested a potential association between cultural norms of masculinity and suicide risk. Norms relating to male emotional suppression, failing to meet standards of male success, and the devaluing of men's interpersonal needs appeared to be associated with increased psychological pain and suicide risk. The '3D Model of Masculine Norms and Male Suicide Risk' (3D Risk), developed to explain these findings, suggests that potential distal and proximal risk factors may be related to the same psychological domains. The model proposes that proximal risk factors are potentially an intensification of the denial, disconnection, and dysregulation of emotions, self, and interpersonal connections identified as distal risk. The model proposes that dysregulation in these domains should intensify as a man moves from thoughts of suicide into a proximal state of attempting to take his own life. These ideas, inductively informed through qualitative work, now need to be investigated through quantitative research designs.

This current study builds on these findings to explore the phenomena of the 3D Risk model in a global, cross-sectional sample, aimed at answering the following research questions:
1. Do higher levels of emotional and psychological pain, negative feelings towards self, and interpersonal challenges (as suggested by the 3D Risk model) increase the odds of being in the (a) suicidal ideation group compared to the control group, (b) suicide attempt group compared to controls, and (c) suicide attempt group compared to the ideation group?

2. What specific socio-demographic factors most increase the odds of being in the (a) suicide attempt group compared to the control group; (b) suicidal ideation group compared to the control group; and (c) suicide attempt compared to the ideation group?

4.3 Methods

The data in the present study are from a large global online survey conducted from March to October 2021 on male suicide risk and recovery factors. Ethical approval was granted by the research ethics committee of the College of Medical, Veterinary, and Life Sciences of the University of Glasgow (application No. 200200085). All participants were aged 18 and over and gave informed consent to take part on a voluntary basis. Participants received no compensation for taking part.

4.3.1 Sample

Identifying as male and being aged 18 or older were the only inclusion criteria. The survey was open to participants worldwide.

4.3.2 Sampling procedures

The survey was built and hosted on online survey software (JISC) and included questions relevant to male suicide risk and recovery. A pilot study was conducted before the survey launched, and men with lived experience provided the research team with feedback on comprehensibility, accessibility, and sensitivity (n = 6). This pilot study aimed to ensure the phrasing of the questions was clear, comprehensive, sensitive and engaging to a male audience and to test the length of completing the study. On average, the survey took 30 minutes to complete. Participant recruitment ran from April to October 2021 and was based on adverts shared with national and local mental health/suicide prevention organisations; depression/male support groups; mental health bloggers; community faith groups; businesses; sports groups; online adverts; Facebook and Reddit groups, and the research team's personal networks. The study advert included a URL to the survey. On the welcome page of the survey, participants could download the 'Participant Information Sheet' (see Appendix 4.1), a 'Consent Form' (see Appendix 4.2) and completed an opt-in "check box" to confirm their

consent to participate. Consenting participants then completed demographic questions before completing the survey questions. Participants could save their responses and finish their entries later should they wish. The survey closed with a debrief message that thanked participants for their time and insights and shared a list of support organisations with relevant contact details. The lead author's email address was made available at the start and end of the survey for any questions or feedback.

4.3.3 Measures

4.3.3.1 Primary Outcome: Suicide-related Measures

To measure participants' history of suicidal behaviours, two items were used from the Adult Psychiatric Morbidity Survey (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2007). To measure past suicide attempts, participants were asked: *'Have you ever made an attempt to take your life?'* Participants who answered 'Yes', were grouped together (Suicide attempt group) to indicate their status as men who had made a previous suicide attempt. To measure participants' past thoughts of suicide, respondents were asked, '*Have you ever thought of taking your life, but not actually attempted to do so?'* Participants who answered 'Yes' and were not in the Suicide attempt group, were grouped together (Suicidal ideation group) to indicate their status as men who had past thoughts of suicide. Men who responded 'No' to both questions were grouped together (Not suicidal or control group) to indicate they had never been suicidal.

4.3.3.2 Sociodemographic Characteristics

The following sociodemographic information were gathered from participants: age (continuous variable), gender (Man / Trans Man / Genderqueer / Prefer not to say), ethnicity (Other than White), sexuality (Other than Straight), relationships status (Married / in a relationship; and Single / Divorced / Separated / Other), employment (Unemployed; Other / Student / Stay at home parent / Retired; and Employed full time / Employed part-time), financial status (Doing alright / Just about getting by; Finding it quite difficult / Finding it very difficult; and Living Comfortably), received a mental health diagnosis (binary coded: yes or no). Data were collected during the Covid-19 pandemic and to measure the impact of

the pandemic on respondents' well-being, participants were asked: ‘How much does Covid-19 affect your life?’; ‘How much does Covid-19 affect your financial situation?’; and ‘How much does Covid-19 affect your mental wellbeing?’ Participants could reply to each question on a Likert-type scale from ‘0 – no effect at all’ to ‘10 - Severely affects my life.’

4.3.3.3 Psychological Variables

The current study constitutes an exploration of psychological factors suggested by the 3D Risk model (Bennett et al., 2023) as relevant to male suicide grouped into three domains: (1) Emotions and psychological pain, (2) Feelings towards self, and (3) Connections with others. A detailed description of each measure is provided in Table 2.2 (Chapter 3 ‘Methods’) and a full copy of all the item questions can be found in Appendix 4.3. While masculine norms are integral to the 3D Risk model, we opted not to use an explicit measure of masculinity following Thompson and Bennett’s (2015) review of masculine ideology psychometrics. The authors argued that given the changing cultural milieu, a new generation of masculinity measures is required to effectively capture contemporary masculine norm construction. Instead, our measures focused on the psychological domains that the 3D Risk model identified as being negatively impacted by cultural norms of masculinity, i.e., male emotional suppression, negative feelings towards self, and interpersonal isolation.

The following section outlines the rationale for the psychological variables selected for this study. For a full breakdown of each scale selected, see Table 2.2 (Chapter 2 ‘Methods).

4.3.3.3.1 Emotions and Psychological Pain Measures

The measures in this domain examine: 1. men's current emotional state, i.e., rates of emotional flooding, entrapment etc., and 2. attitudes towards expressing and managing emotion. Men’s current emotional state was measured using:

> a) Depression PHQ (Kroenke, Spitzer & Williams, 2001) a 9-item measure of depression in the last 2 weeks, though we only used 8 of the 9 items removing question 9 - “Have you had thoughts that you would be better off dead or of hurting yourself in some way?” - because of potential crossover with our outcome measure of suicide ideation or attempt. The measure has four response options (‘Not at all’ to

'Nearly every day'). Good internal consistency and construct validity have previously been reported (Kroenke, Spitzer & Williams, 2001) and in this study, the scale displayed high internal reliability (Cronbach's a=0.90).

b) Entrapment Scale (De Beurs et al., 2020), a 4-item measure of entrapment (e.g., "I feel trapped inside myself"), with five response options ('Not at all like me' to 'Extremely like me'). This measure has good internal consistency and construct validity and displays good psychometric properties (De Beurs et al., 2020). In this study, the scale displayed high internal reliability (Cronbach's a=0.87)

c) Defeat Scale (Griffiths et al., 2015); a 4-item measure of defeat (e.g., "'I feel defeated by life'"), with five response options ('Not at all like me' to 'Extremely like me'). This measure has good internal consistency and construct validity and displays good psychometric properties (Griffiths et al., 2015). In this study, the scale displayed high internal reliability (Cronbach's a=0.92).

d) Flooding & Freezing sub-scales from the Mental Pain Scale (Orbach et al., 2003). We used 7 items to measure flooding and freezing (e.g., "I am flooded by many feelings") with 5 response points ('Does not describe me at all' to 'Describes me very well'). This measure has good internal consistency and construct validity and displays good psychometric properties (Orbach et al., 2003). In this study, the scale displayed high internal reliability (Cronbach's a=0.86).

Men's attitudes to emotional expression were measured via.

a). 'Self-Reliance' and 'Emotional Control' sub-scales from the Conformity to Masculine Norms (Mahalik et al., 2003); 6-items in total (e.g., "I tend to share my feelings") with six response options ('Strongly Disagree' to 'Strongly Agree'). This measure has good internal consistency and construct validity and displays good psychometric properties (Mahalik et al., 2020). In this study, the scale displayed high internal reliability (Cronbach's a=0.81)

b) Attitudes towards Emotional Expression scale (Joseph et al., 1994), a 20-item measure of emotional expression (e.g., "I think getting emotional is a sign of

weakness") with five response options ('Strongly Disagree' to 'Strongly Agree'). This measure has good internal consistency and construct validity and displays good psychometric properties (Joseph et al., 1994).). In this study, the scale displayed high internal reliability (Cronbach's a=0.92)

4.3.3.3.2 Feelings and Thoughts about Self

This domain of 3 measures assessed men's feelings and attitudes towards themselves:

a). Self-Esteem Scale (Rosenberg, 1965) a 10-item measure of self-esteem (e.g., "I certainly feel useless at times") with four response options ('Strongly Agree' to 'Strongly Disagree'). This measure has good internal consistency and construct validity and displays good psychometric properties (Donnellan, Trzesniewski & Robins, 2015). In this study, the scale displayed high internal reliability (Cronbach's a=0.91).

b). Self-Liking/Self Competence Scale (Tafarodi & Swann, 1995) a 16-item measure of self-liking and self-competence (e.g., "I never doubt my personal worth") with four response options ('Strongly Agree' to 'Strongly Disagree). This measure has good internal consistency and construct validity and displays good psychometric properties (Donnellan, Trzesniewski & Robins, 2015). In this study, the scale displayed high internal reliability (Cronbach's a=0.92).

c). Failure (1 measure from BDI-II) with three response options ('I have failed more than I should have' to 'I feel I am a total failure as a person'). This measure has good internal consistency and construct validity and displays good psychometric properties (Wang & Gorenstein, 2013).

4.3.3.3.3 Connections with others

In this domain, men's sense of mattering to others, their social and emotional isolation, and connections with a significant other, friends and/or family, were measured via:

a). Multidimensional Scale of Perceived Social Support (Zimet et al., 1988); a 12-item measure of support from family, friends, and significant others (e.g., "I can count on my friends when things go wrong"), with seven response options ('Very Strongly Disagree' to 'Very Strongly Agree'). This measure has good internal consistency and construct validity and displays good psychometric properties (Zimet et al., 1988). In this study, the scale displayed high internal reliability (Cronbach's a=0.92)

b). The De Jong Gierveld Loneliness Scale (Gierveld & Van Tilburg, 2006); a 6-item measure of social and emotional loneliness (e.g., "I miss having people around me"), with five response options ('Yes!' to 'No!'). This measure has good internal consistency and construct validity and displays good psychometric properties (Gierveld & Van Tilburg, 2006). In this study, the scale displayed high internal reliability (Cronbach's a=0.80)

c). General Mattering Scale (Marcus, 1991) a 5-item measure of mattering to others (e.g., "How important are you to others?"), with four response options ('Not at all' to 'Very much'). This measure has good internal consistency and construct validity and displays good psychometric properties (Sari & Karaman, 2018). In this study, the scale displayed high internal reliability (Cronbach's a=0.86)

4.3.4 Missing Data

Missing data was relatively low, with 'Age' missing at 4.73%, 'Mental Health Diagnosis' at 4.02% and all other scales missing at under 1%. The missing completely at random test (Little, 1988) was used to establish patterns in the missing data. The test was non-significant, suggesting that data were missing completely at random. The expectation maximisation technique was used to address missing data (Rubin, 1987). The imputation procedures were only applied to continuous variables (i.e., categorical data were not included).

4.3.5 Statistical Analysis

Data were cleaned and grouped into two classification models with the reference group for Model 1 set as men who are not suicidal and in Model 2 as men with suicidal ideation. Model

1 explored: (a) men who are not suicidal (reference: not suicidal) vs men with thoughts of suicide (ideation); and (b) men who are not suicidal (reference: not suicidal) vs men who have attempted suicide (attempt). Model 2 compared (c) men with thoughts of suicide (reference: ideation) vs men who have attempted suicide (attempt).

First, we descriptively summarised demographic and psychological data through frequencies, percentages, means, and standard deviations. Separate multinomial univariate logistical regressions were then conducted on each variable in each model with odds ratios (OR) and 95% CIs are reported in Table 4.1. Variables statistically significant at p-value <0.01 across the 2 models were added to a multinomial multivariate logistical regression analysis. Multicollinearity tests were carried out to check the correlation between independent variables in the multivariate model. Collinearity on variables in Model 1 were low, medium, and high, so results for these models need to be interpreted with appropriate caution. Collinearity on variables in Model 2 were all confirmed as low (see Appendix 4.6). For all measures, Cronbach Alpha was 0.80 and above. Odds ratios (OR) and 95% CIs are reported for this regression in Table 4.2, along with the model fit statistics. A risk factor was deemed significant if the p-value was <0.01. The p-value was set at <0.01 to account for the multiple comparisons in this study. See Appendix 4.7 for a breakdown of all the variables included in the multivariate analysis and the sociodemographic reference categories. All analyses were conducted using R version 4.2.2 - see Appendix 4.8 for a sample of the analysis script.

4.4 Results

4.4.1 Suicidal History

There were 2,763 men in the study sample. Overall, 781 (29%) men reported a lifetime suicide attempt, 1,670 (60%) participants reported lifetime suicidal ideation, and 312 (11%) participants reported no suicidal history.

4.4.2 Participant Characteristics

Of the 2,763 men in the sample, 1,681 were aged 18-30 (61%); 845 were aged 31 to 50 (31%); and 237 were 51 and older (9%) The majority of the sample was white (81%), straight

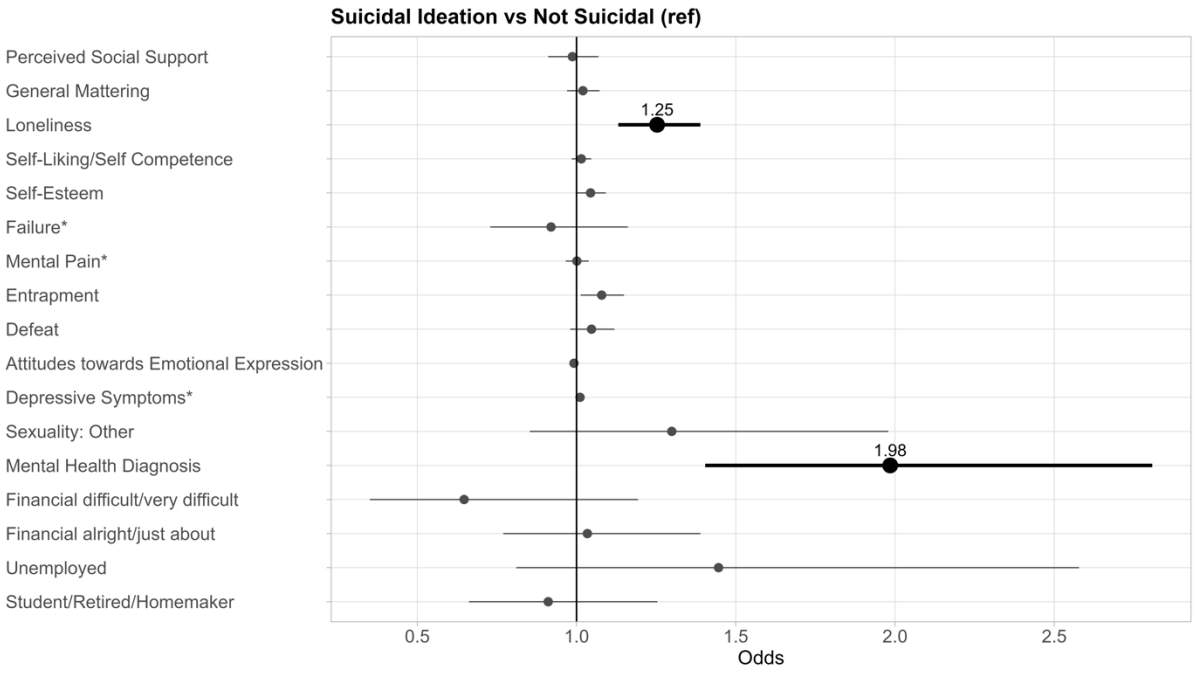
(77%), employed (59%), not in a relationship (61%) and financially ‘Doing alright / Just about getting by’ (59%). The sample included men from 79 countries, with representation across World Bank regions as follows: Europe & Central Asia (50.92%), North America (35.69%), East Asia & Pacific (6.33%), Latin America & Caribbean (3.76%), South Asia (2.14%), Sub-Saharan Africa (0.51%), and Middle East & North Africa (0.51%) (World Bank, 2023). The mean impact of Covid-19 on participants was 5 out of 10 (SD = 2.85); the mean for impact on wellbeing was 5 out of 10 (SD = 3.10); and 3 out of 10 for impact on financial situation (SD = 3.14). Men from 79 countries were represented in the sample and full demographic and psychosocial characteristics broken down by suicidal history can be found in Appendix 4.4 and 4.5.

4.4.3 Factors increasing the odds of suicidal ideation category membership (compared to no suicidal history)

In the univariate multinomial logistic regression (see Table 4.1 for full breakdown), demographic factors that significantly increased the likelihood of suicidal ideation category membership compared to the control group were: being aged 51+, not straight, not married or in a relationship, unemployed, mental health diagnosis, and any category of financial strain. Explanatory psychological factors included higher rates of depressive symptoms, emotional control, self-reliance, mental pain, entrapment, defeat, failure, emotional and social loneliness; more negative attitudes to emotional expression; and lower perceived social support, mattering to others, self-esteem, self-liking, and self-competence.

In the multivariate multinomial logistic regression model, the factors that significantly increased the odds of ideation group membership vs not suicidal were loneliness [OR (95% CI) = 1.25 (1.13, 1.39) $p < 0.0001$], and having a mental health diagnosis [OR (95% CI) = 1.99 (1.40, 2.81) $p < 0.0001$]. See Figure 4.1 and Table 4.2.

Figure 4.1 Forest plots of factors distinguishing men with thoughts of suicide from men with no suicidal history



Notes: The vertical line represents the non-significance (null) line (OR = 1). Circles represent the OR values located on the x-axis OR scale (the bigger the circle, the higher the OR value). Lines crossing the circles represent the extent of the 95% confidence intervals. 95% CI lines crossing/touching the null line indicate no association.

* = Sub-scales rather than full scale used

Table 4.1: Univariate multinomial logistic regression of demographic, mental health characteristics and psychological associated with suicidal history group membership

Demographic and Clinical Variables

Model Variables	Suicidal Ideation vs No Suicidal History*		Suicide Attempts vs No Suicidal History*		Suicidal Thoughts vs Suicide Attempts**	
	Unadjusted OR (95% CI)	P value	Unadjusted OR (95% CI)	P value	Unadjusted OR (95% CI)	P value
Age						
Age 51+	0.41 (0.29, 0.6)	**0.0001**	0.46 (0.31, 0.7)	**0.0001**	1.11 (0.81, 1.53)	0.51
Age 31-50	0.89 (0.68, 1.17)	0.42	0.89 (0.66, 1.2)	0.46	1 (0.83, 1.21)	1
Age 18-30 (ref)	-	-	-	-	-	-
Gender						
Trans Men	3.07 (0.73, 12.99)	0.13	13.55 (3.26, 56.27)	**0.0001**	4.41 (2.86, 6.82)	**0.0001**
Cis-Male (ref)	-	-	-	-	-	-
Sexuality						
Other than Straight	2.21 (1.51, 3.23)	**0.0001**	4.39 (2.97, 6.49)	**0.0001**	1.99 (1.64, 2.4)	**0.0001**
Straight (ref)	-	-	-	-	-	-
Ethnicity						
Other than white	1.11 (0.81, 1.52)	0.53	1.22 (0.87, 1.72)	0.25	1.1 (0.89, 1.37)	0.36

White (ref)	-	-	-	-	-	-
Relationship Status						
Single or divorced or separated or Widowed or Other	2.1 (1.64, 2.68)	**0.0001**	2.46 (1.88, 3.21)	**0.0001**	1.17 (0.98, 1.4)	0.08
Married or in a relationship (ref)	-	-	-	-	-	-
Employment						
Unemployed	3.46 (2.07, 5.77)	**0.0001**	5.6 (3.32, 9.45)	**0.0001**	1.62 (1.3, 2.02)	**0.0001**
Other / Student / Stay at home parent / Retired	1.12 (0.85, 1.48)	0.43	1.14 (0.84, 1.56)	0.4	1.02 (0.83, 1.26)	0.84
In employment (ref)	-	-	-	-	-	-
Financial						
Doing alright / Just about getting by	2.16 (1.68, 2.78)	**0.0001**	3.18 (2.37, 4.27)	**0.0001**	1.47 (1.18, 1.83)	**0.0001**
Finding it quite difficult / Finding it very difficult	3.32 (1.98, 5.58)	**0.0001**	9.75 (5.7, 16.69)	**0.0001**	2.93 (2.22, 3.87)	**0.0001**
Living comfortably (ref)	-	-	-	-	-	-
Mental Health Diagnosis						
yes	3.77 (2.75, 5.17)	**0.0001**	11.94 (8.53, 16.73)	**0.0001**	3.17 (2.64, 3.8)	**0.0001**
no (ref)	-	-	-	-	-	-
	Psychological Variables					
Model Variables	Suicidal Ideation vs No Suicidal History*		Suicide Attempts vs No Suicidal History**		Suicidal Thoughts vs Suicide Attempts**	
	Unadjusted OR (95% CI)	**P value**	**Unadjusted OR (95% CI)**	**P value**	**Unadjusted OR (95% CI)**	**P value**
Emotional and Psychological Pain:						

Depression *(from PHQ)*	1.20 (1.17, 1.23)	**0.0001**	1.3 (1.26, 1.34)	**0.0001**	1.08 (1.07, 1.1)	**0.0001**
Conformity to Masculine Norms *(Emotions and Self Reliance)*	1.35 (1.21, 1.5)	**0.0001**	1.46 (1.29, 1.64)	**0.0001**	1.08 (1, 1.17)	0.05
Attitudes to Emotions	1.04 (1.03, 1.05)	**0.0001**	1.06 (1.05, 1.07)	**0.0001**	1.02 (1.01, 1.03)	**0.0001**
Mental Pain *(Flooding and Freezing)*	1.17 (1.15, 1.2)	**0.0001**	1.25 (1.22, 1.28)	**0.0001**	1.07 (1.05, 1.08)	**0.0001**
Entrapment	1.28 (1.24, 1.33)	**0.0001**	1.4 (1.35, 1.45)	**0.0001**	1.09 (1.07, 1.11)	**0.0001**
Defeat	1.29 (1.24, 1.34)	**0.0001**	1.4 (1.35, 1.46)	**0.0001**	1.09 (1.07, 1.1)	**0.0001**
Feelings about Self:						
Failure *(from BDI-II)*	2.71 (2.33, 3.16)	**0.0001**	4.2 (3.56, 4.95)	**0.0001**	1.55 (1.41, 1.69)	**0.0001**
Self-Esteem Scale	1.17 (1.15, 1.19)	**0.0001**	1.25 (1.22, 1.28)	**0.0001**	1.07 (1.05, 1.09)	**0.0001**
Self-Liking/Self-Competence	1.11 (1.1, 1.13)	**0.0001**	1.17 (1.15, 1.19)	**0.0001**	1.05 (1.04, 1.06)	**0.0001**
Connections with Others:						
Perceived Social Support	0.78 (0.73, 0.83)	**0.0001**	0.73 (0.68, 0.78)	**0.0001**	0.93 (0.9, 0.97)	**0.0001**
General Mattering Scale	0.83 (0.8, 0.86)	**0.0001**	0.76 (0.73, 0.79)	**0.0001**	0.92 (0.9, 0.94)	**0.0001**
Loneliness Scale	1.70 (1.58, 1.82)	**0.0001**	1.99 (1.83, 2.15)	**0.0001**	1.17 (1, 1.24)	**0.0001**

*Reference category: no suicidal history

**Reference category: suicidal thoughts

Table 4.2: Multivariate multinomial logistic regression of psychosocial factors variables associated with suicidal history group membership

Model Variables	Suicidal Ideation vs No Suicidal History*		Suicide Attempts vs No Suicidal History**		Suicidal Thoughts vs Suicide Attempts**	
	Adjusted OR (95% CI)	**P value**	**Adjusted OR (95% CI)**	**P value**	**Adjusted OR (95% CI)**	**P value**
Emotional and Psychological Pain:						
Depressive Symptoms *(from PHQ)*	1.0 (1.00, 1.03)	0.116	1.02 (1.00, 1.03)	0.016	1.01 (1.00, 1.01)	0.045
Attitudes to Emotions	0.99 (0.98, 1.00)	0.163	1.01 (0.99, 1.02)	0.398	1.01 (1.01, 1.02)	**0.000**
Mental Pain *(Flooding and Freezing)*	1.00 (0.97, 1.04)	0.935	1.03 (0.99, 1.07)	0.219	1.02 (1.00, 1.05)	0.027
Entrapment	1.08 (1.01, 1.15)	0.018	1.06 (0.99, 1.14)	0.090	0.98 (0.95, 1.02)	0.371
Defeat	1.05 (0.98, 1.12)	0.174	1.05 (0.98, 1.13)	0.158	1.01 (0.97, 1.04)	0.761
Feelings about Self:						
Failure *(from BDI-II)*	0.92 (0.73, 1.16)	0.481	1.01 (0.78, 1.31)	0.915	1.10 (0.95, 1.28)	0.188
Self-Esteem Scale	1.04 (1.00, 1.09)	0.059	1.05 (1.00, 1.11)	0.058	1.01 (0.98, 1.04)	0.685
Self-Liking/Self-Competence	1.02 (0.99, 1.05)	0.320	1.01 (0.97, 1.04)	0.785	0.99 (0.97, 1.01)	0.347
Connections with Others:						
Perceived Social Support	0.99 (0.91, 1.07)	0.748	1.00 (0.92, 1.10)	0.947	1.02 (0.97, 1.07)	0.507
General Mattering Scale	1.02 (0.97, 1.07)	0.443	0.98 (0.92, 1.03)	0.375	0.96 (0.93, 0.99)	**0.005**
Loneliness Scale	1.25 (1.13, 1.39)	**0.000**	1.16 (1.02, 1.30)	0.020	0.92 (0.85, 1.00)	0.048

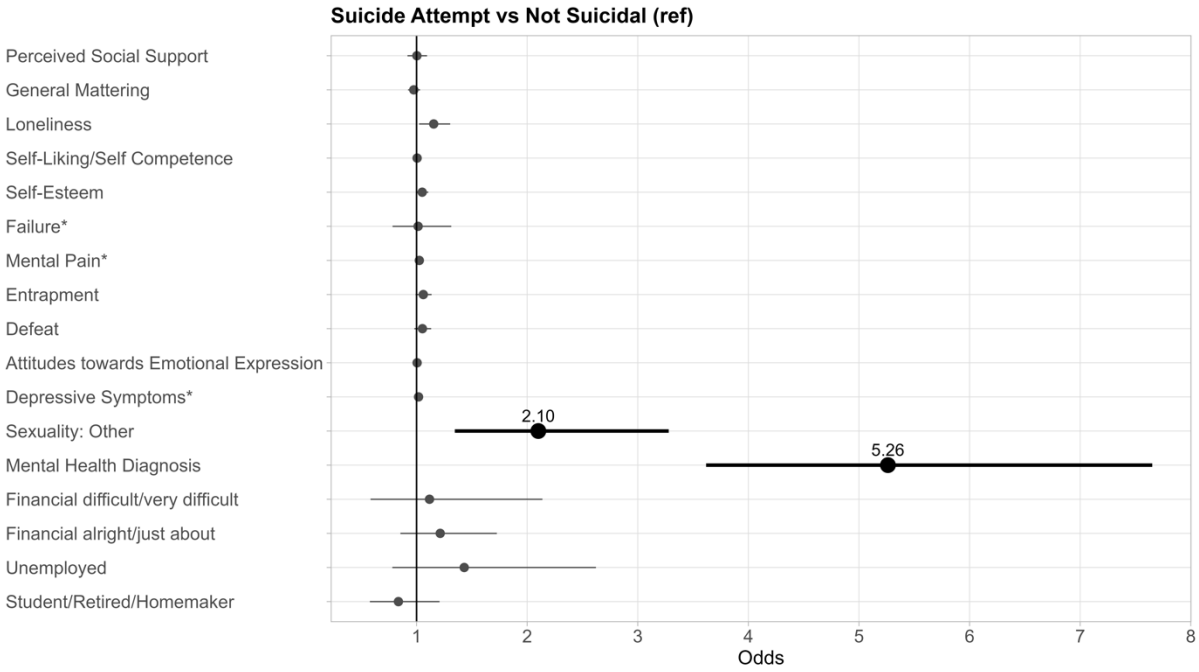
Sociodemographic						
Sexuality (not straight)	1.30 (0.85, 1.98)	0.222	2.10 (1.35, 3.28)	**0.001**	1.62 (1.32, 1.98)	**0.000**
Student / Stay at home parent / Retired	0.91 (0.66, 1.25)	0.568	0.84 (0.58, 1.21)	0.340	0.92 (0.73, 1.15)	0.456
Unemployed	1.45 (0.81, 2.58)	0.211	1.43 (0.78, 2.62)	0.245	0.99 (0.77, 1.27)	0.936
Doing alright / Just about getting by	1.03 (0.77, 1.39)	0.824	1.21 (0.85, 1.73)	0.280	1.17 (0.93, 1.48)	0.178
Finding it quite difficult / Finding it very difficult	0.65 (0.35, 1.19)	0.163	1.12 (0.58, 2.14)	0.738	1.73 (1.26, 2.37)	**0.001**
Has a Mental Health Diagnosis	1.99 (1.40, 2.81)	**0.000**	5.26 (3.62, 7.65)	**0.000**	2.65 (2.18, 3.22)	**0.000**

4.4.4 Factors increasing the odds of suicide attempt category membership (compared to no suicidal history)

In the univariate multinomial logistical regression (see Table 4.1 for full breakdown), the same demographic and psychological factors that significantly increased suicidal ideation group membership compared with controls were also found to be statistically significant here (suicide attempt vs controls), though gender other than 'male' was also significant here.

In the multivariate multinomial logistical regression, factors that significantly increased suicide attempt category membership were: sexuality i.e., not being heterosexual [OR (95% CI) = 2.10 (1.35, 3.28) $p < 0.001$]; and having a mental health diagnosis [OR (95% CI) = 5.26 (3.62, 7.65) $p < 0.0001$]. See Figure 4.2 and Table 4.2.

Figure 4.2 Forest plots of factors distinguishing men who have made a suicide attempt from men with no suicidal history



Notes: The vertical line represents the non-significance (null) line (OR = 1). Circles represent the OR values located on the x-axis OR scale (the bigger the circle, the higher the OR value). Lines crossing the circles represent the extent of the 95% confidence intervals. 95% CI lines crossing/touching the null line indicate no association.

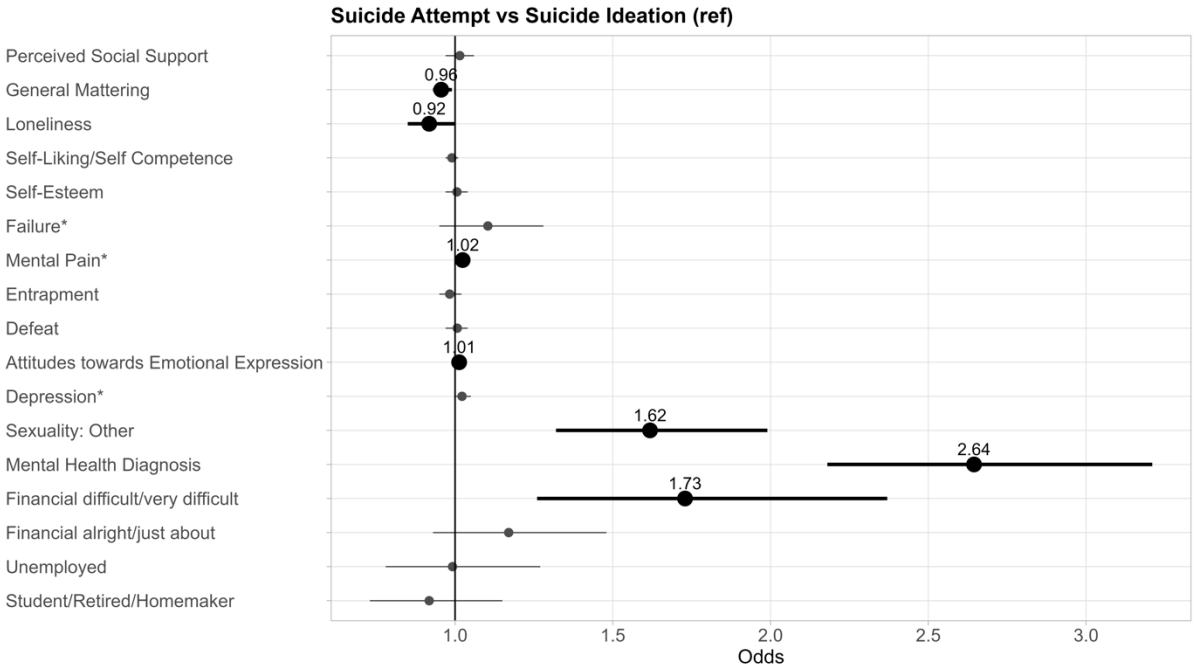
* = Sub-scales rather than full scale used

4.4.5 Factors increasing the odds of suicide attempt category membership (compared to suicidal ideation)

In the univariate multinomial logistical regression (see Table 4.1 for full breakdown), the demographic factors that significantly increased the likelihood of suicide attempt category membership compared to suicidal ideation membership were: not being a cis male, not being straight, being unemployed, having a mental health diagnosis, and any category of financial strain. Psychological factors that increased the odds of belonging to the suicide attempt group were: higher rates of depressive symptoms, mental pain, entrapment, defeat, failure, emotional and social loneliness; more negative attitudes to emotional expression; and lower perceived social support, mattering to others, self-esteem, self-liking and self-competence.

In the multivariate multinomial logistical regression, the factors that significantly increased the odds of being a man who had attempted (compared with experiencing only suicidal ideation) were: sexuality, i.e., not being heterosexual [OR (95% CI) = 1.62 (1.32, 1.98) $p < 0.0001$]; having a mental health diagnosis [OR (95% CI) = 2.65 (2.18, 3.22) $p < 0.0001$]; finding it financially quite difficult and very difficult [OR (95% CI) = 1.73 (1.26, 2.37) $p < 0.01$]; having more restrictive attitudes towards emotional expression [OR (95% CI) = 1.01 (1.01, 1.02) $p < 0.0001$]; and reporting lower rates of general mattering [OR (95% CI) =0.96 (0.93, 0.99) $p < 0.005$]. See Figure 4.3 and Table 4.2.

Figure 4.3 Forest plots of factors distinguishing men with thoughts of suicide from men who have made a suicide attempt



Notes: The vertical line represents the non-significance (null) line (OR = 1). Circles represent the OR values located on the x-axis OR scale (the bigger the circle, the higher the OR value). Lines crossing the circles represent the extent of the 95% confidence intervals. 95% CI lines crossing/touching the null line indicate no association.

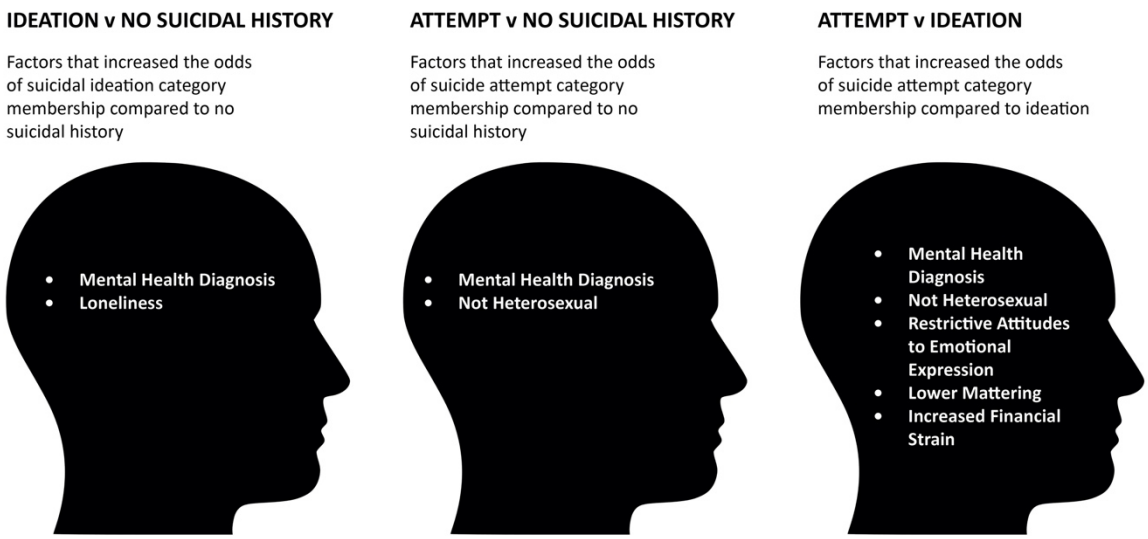
* = Sub-scales rather than full scale used

4.5 Discussion

The current study aimed to investigate whether increased levels of emotional and psychological pain (domain 1), negative feelings towards self (domain 2), and difficulties with interpersonal connections (domain 3) increased the odds of group membership to the suicidal ideation category (compared to controls), the suicide attempt group (compared to controls), suicide attempt group (compared to the suicidal ideation category). Our findings suggest that worse levels in all these domains (as suggested by the 3D Risk model) increased the odds of suicidal ideation and/or a suicide attempt compared to men with no suicidal history, and of a suicide attempt compared with suicidal ideation. Specific factors that appeared to increase the odds of suicidal ideation category membership compared to controls were higher levels of loneliness and having a mental health diagnosis. Not being heterosexual and having a mental health diagnosis increased the odds of suicide attempt category

membership compared to controls. Finally, variables that increased the odds of suicide attempt group membership compared to suicidal ideation were higher levels of restrictive attitudes to emotional expression, lower levels of mattering to others, not being heterosexual, increased financial strain, and having a mental health diagnosis. See Figure 4.4 for an overview.

Figure 4.4 Distinguishing factors between group membership categories



4.5.1 Sociodemographic Risk Factors

4.5.1.1. Mental Health

Our findings indicate that having a mental health diagnosis significantly increases the likelihood of experiencing suicidal thoughts or attempting suicide compared to men who are not suicidal, and increases odds of a suicide attempt compared to ideation. These findings are consistent with the quantitative systematic review that identified depression as a significant risk factor for male suicide (Richardson et al., 2021). Similarly, a recent study of African American men found that men with major depressive episodes were at higher suicide risk (Omary, Richardson & Chambers, 2021). Still, the relationship between mental health and suicide risk is complex. It has previously been reported that 90% of people who die by suicide have a mental health diagnosis though the reliability of that statistic is now contested (Bryan, 2022; Hjelmeland & Knizek, 2017; Kõlves, Kumpula & De Leo, 2013). Evidence suggests men are more likely to die without a mental health diagnosis or prior contact with

mental health services (Jordan & McNiel, 2020; Fowler et al., 2022; Tang et al., 2022). More research is required to understand the nuances of the relationship between mental health and male suicide risk. Mental health presentations may differ between men and women, meaning mental health conditions in men may be unrecognised and underreported (Kõlves et al., 2013). We also need to understand which mental health conditions are most relevant to male suicide, and what other factors interact with mental health to elevate risk, given that most people with a mental health diagnosis do not die by suicide (Hjelmeland & Knizek, 2017). It may also be important to consider how men understand their mental health and suicidal pain. Evidence from qualitative studies suggests that being diagnosed with a mental health condition can be a source of shame or failure for men who are suicidal (Creighton et al., 2017; Strike et al., 2006). Further research could enhance our understanding of effective approaches to framing discussions on mental health and suicide that genuinely engage and resonate with men who are at risk.

4.5.1.2 Financial Struggles

Differences distinguishing men who have attempted suicide from men with lifetime thoughts of suicide also included financial challenges. Previous research has suggested a link between financial debt and suicide (Meltzer et al., 2011). Male suicide rates increased after the global financial crisis in 2007-2008 (Whitley, 2021). Exploring the relationship between financial challenges and male suicide risk may be increasingly important as we confront the global economic fallout from COVID-19 and the cost-of-living crisis. It is unclear from our data what the sources of financial challenges in men's lives were. Many factors could be relevant, from insecure employment to the cost of living, gambling debts, or risky investments. More work is required to understand this context. It may also be important to consider how much men value financial stability and success as sources of masculine identity and social value. Scholars have suggested that dominant cultural norms of male financial success may leave some men vulnerable to internalising feelings of failure if they perceive themselves to be financially struggling (Kõlves et al., 2013; Swami et al., 2008). Qualitative work suggests that across cultural contexts, including Nepal (Hagaman et al., 2018), Ghana (Andoh-Arthur, et al., 2018), Australia (Fitzpatrick, 2014), and Norway (Kiamanesh, Dieserud & Haavind, 2015), men who financially struggle perceived this to represent failed masculinity and contributed to their suicidal despair. The potential link between financial challenges and suicide risk suggests the potential importance of interventions that take a holistic view of

men's pain, such as providing emotional and financial support in combination. A recent pilot randomised trial of an intervention that combined psychosocial and financial support for people admitted to hospitals in acute distress showed feasibility (Barnes et al., 2018). Integrating suicide awareness and interventions within agencies that support men with financial challenges, debt, and/or gambling problems may also be valuable.

In Pirkis' (2000) study exploring differences between people who are not suicidal, people who experience suicidal ideation, and people who had attempted suicide, unemployment significantly increased the odds of having attempted suicide compared to those with no suicidal history, and those with suicidal ideation. Interestingly, in our male-only data, unemployment did not increase the odds of a suicide attempt, but financial circumstances did. This suggests that being unemployed may not be a sufficiently sensitive marker of male suicide risk compared to a perceived lack of financial resources. This could have potential policy relevancy, suggesting support for economically vulnerable men to alleviate financial pressures, may help reduce potential suicide risk.

4.1.5.3 Sexuality

Sexuality, i.e., not being straight, was a distinguishing factor between men who have attempted and men with no suicidal history and between men who have attempted suicide and men with suicidal ideation. Sexuality as a risk factor for suicide is well established (Sunderland et al., 2023). A recent systematic review and meta-analysis found that LGBTIQ people had a higher risk of suicide than heterosexual and cisgender people (Marchi, et al., 2022). Like mental health, more research is required to explore the dynamic between sexuality and suicide, given that most gay or bisexual men do not die by suicide. What puts specific non-heterosexual men at risk? Findings also suggest the potential importance of continued population-level campaigns to tackle homophobia.

4.5.2 Psychological Risk Factors

4.5.2.1 Attitudes to Emotional Expression

More restrictive attitudes towards emotional expression significantly increased the odds of group membership to the suicide attempt category over men with suicidal ideation, though

the effect size was small. The Attitudes to Emotional Expression (AEE) scale used in this study was created to explore how attitudes towards emotional expression impact how people cope with stressful events (Joseph et al., 1994). The AEE authors conceived of seeking social support as a valuable coping strategy for managing stress. They hypothesised that restrictive attitudes towards emotional expression may curb external support-seeking and limit a person's ability to be helped by others (Joseph et al., 1994). The potential relationship found in this study between restrictive attitudes to emotional expression and increased male suicide risk is borne out in previous qualitative work. Studies suggest a potential association between increased male suicide risk and male emotional suppression, disconnection, and dysregulation (Bennett et al., 2023; Cleary, 2005). Quantitative studies have also shown emotional suppression to predict increased suicidal ideation within a German mixed in-patient sample (Forkmann et al., 2014), and higher restrictive emotionality has been linked to increased suicidality in US high school students (Jacobson et al., 2011).

The relationship between restricted emotional expression and increased suicide risk aligns with theories highlighting psychological pain as a core driver of suicidal behaviours (Joiner, 2005; Shneidman, 1993). If high psychological pain increases suicide risk, then tools to regulate that pain, such as effective emotional regulation, may reduce risk. Part of effective emotional regulation may be the sharing of emotions with others. A meta-analytic review of the relationship between emotional regulation and psychopathologies found that emotional suppression had medium to large effects on anxiety, depression, eating, and substance-related disorders (Aldao, Nolen-Hoeksema & Schweizer, 2010). Given that psychological pain is a driver of suicide, men who have attempted suicide are potentially more likely to have experienced higher levels of psychological pain than men with suicidal ideation. This, coupled with more restrictive attitudes towards emotional expression, may leave some men vulnerable to perceiving suicide as the only way to cope with their suffering. Our findings require further investigation but support the potential utility of exploring interventions and tools to support men’s emotional regulation and expression. This work may also need to entail population-level campaigns to change cultural attitudes toward male emotionality, normalise male distress expression, and upskill the public's response to men in distress (Bennett et al., 2023).

4.5.2.2 Mattering

Our findings suggest that men who have attempted suicide may perceive themselves as mattering less to others than men who only experience suicidal thoughts, though again the effect size was small. The General Mattering Scale (GMS) used in this study is a 5-item measure relating to things such as how important a person feels to others, and how much attention and interest is paid to them. Higher scores suggest a higher perceived sense of mattering. The GMS is based on Rosenberg and McCullough's (1981) concept of mattering, developed in response to the idea of 'significant others' taking hold in psychology - an awareness that some people matter more to us than others. Rosenberg and McCullough (1981) proposed that along with considering certain people to be more significant, humans also developed a sense of the extent to which they matter to others, i.e., the extent to which they are significant to people. Higher rates of general mattering may have protective health values, with studies suggesting a link between general mattering and wellness in men (Rayle, 2005) and reduced depression and anxiety (Dixon, Scheidegger & McWhirter, 2009). Joiner et al. (2009) explored mattering within a mixed-gender sample aged 19 to 26 and found it predictive of the severity of suicidal ideation. Elliot et al. (2005) used a different mattering measure in their study with adolescents aged 11 to 18. Still, they found lower rates of mattering predictive of increased suicidal ideation, mediated by reduced self-esteem and higher depression. While mattering was significant in our study the mediating role of depression and self-esteem could be explored in future studies.

Future research could also explore gender dimensions of mattering and how different genders construct their sense of mattering. The General Mattering Scale (GMS) has been used in research with adolescent populations where findings suggest women perceive themselves as mattering more to others (Rayle, 2005). Studies using other measures of mattering have supported this hypothesis (Taylor & Turner, 2001). It may be that certain cultural norms impact how men evaluate their sense of mattering. Scholars have suggested that traditional masculine norms can place cultural emphasis on men as economic providers rather than relational beings. This emphasis may isolate some men from the protective values of sharing and cultivating intimate connections with others (Levant, 1996; Swami et al., 2008). Cultural norms that devalue men's interpersonal needs could leave some men vulnerable to not perceiving how they matter to others in an emotional/relational context. Similarly, there may be a potential link between financially struggling, reduced mattering, and male suicide risk. If some men understand they matter through their ability to provide financially, then financial struggles could reduce some men's sense of mattering, and increase suicide risk. Our findings

require further investigation, including qualitative work, to explore the phenomenological experience of mattering - what makes a man feel like he matters to others? It is important to emphasise that mattering is a personal perception and not necessarily a reflection of the value, regard, and affection held by significant others towards a man who is suicidal. Men's perceptions of mattering may also relate to other psychological phenomena. For example, restrictive attitudes to emotional expression may limit intimacy in men's interpersonal connections and inhibit men from asking for, and receiving validation of themselves, as meaningful to others. Prevention and intervention work that broadly seeks to support and provide men with the tools and opportunities to build meaningful connections with others may be valuable. Similarly, therapeutic interventions that work with men and significant others may also be useful to bring men into a sense of mattering to those who matter to them. Randomised controlled trials (RCTs) of family interventions for suicidal adolescents have yielded positive outcomes (Diamond et al., 2010; Pineda & Dadds, 2013).

4.5.2.3 Loneliness

Higher feelings of loneliness also significantly increased the odds of suicidal ideation over men with no suicidal history, though this effect size was relatively small. In a recent Delphi study working with lived experience experts to develop an agenda of priorities for male suicide research, the highest endorsed item was 'investigating loneliness and isolation for men who are suicidal' (98% endorsement) (Bennett et al., 2023). Further research is needed to explore the specific areas of life where men experience loneliness, such as family, friendships, and romantic relationships, the barriers that hinder men from forming meaningful connections, and strategies to overcome these.

4.5.3 Theoretical and Clinical Implications

Findings that suggest loneliness and mattering to others may be relevant to male suicide risk support the theoretical importance of interpersonal connections to understanding suicide (Joiner, 2005; Leenaars, 1996). Similarly, restrictive attitudes to emotional expression among men who have attempted suicide support the suggestion from Study 1, Chapter 3, that understanding men's emotional regulation be theoretically integrated into understanding male suicide risk (Bennett et al., 2023). From a clinical perspective, interventions that support men's emotional regulation and expression, strengthen men's ability to build meaningful

connections with others, support to overcome the psychological damage of homophobia, and/or manage mental health challenges may be valuable. Additionally, structural interventions to alleviate financial challenges may be necessary alongside psychological support.

4.5.4 Future Research

Many of the effect sizes for the psychological variables were relatively small and our findings need to be replicated in future research. We have suggested potential recommendations for some of this work throughout the discussion. Additionally, while our results provide insight into potential cross-sectional distal psychological distinctions between men experiencing different degrees of suicidality, they do not give insight into what factors are relevant when a shift from thinking about suicide to attempting happens in real-time (Bryan & Rudd, 2016). An important area for future research will be real-time monitoring of psychological shifts as men move in and out of feelings of suicide and attempting. Similarly, suicide is a complicated behaviour with multiple drivers (Shneidman, 1993). Risk factors have tended to be studied in isolation rather than in interaction, yielding simplified, uni-dimensional insights into a much more complex behaviour (Franklin et al., 2017; Van Orden et al., 2010). We do not have a robust enough understanding of risk factors in dynamic interaction, meaning findings such as those in this study are limited in what they can illuminate. The high collinearity in two of our models suggests the constructs examined are potentially related, and future research using a methodology such as a network analysis to explore complex interactions between risk variables may be helpful in further illuminating specific psychological profiles of men experiencing different degrees of suicidality. Future research could also explore risk factors not included in this study such as childhood adversity and substance abuse which have been suggested to be relevant to suicide in men (Richardson et al., 2021; Richardson et al., 2022).

4.5.5 Limitations

The validity of our findings are limited by the fact that men who have died by suicide cannot be directly studied and may be qualitatively different to men with thoughts of suicide and/or men who have attempted. This limitation applies to all suicide research. Our cross-sectional, retrospective design means we cannot comment on directionality or causality. Unless men in

our sample were actively suicidal at the time of participating in the survey, their responses may not provide an accurate insight into risk factors at the exact point of a suicidal crisis, and participant's responses may be subject to recall bias (De Leo et al., 2006). In keeping with previous research, predominately white men from Western contexts dominated our sample (O'Connor & Nock, 2014). Men of different ethnic backgrounds, sexualities, and abilities, and in different cultural locations, may experience risk factors uniquely. Similarly, the sample will be subject to potential self-report and self-selection bias. The difficulties of operationalising certain variables also limit findings. For example, the binary classification of mental health, while expedient, lacks the nuance necessary for a comprehensive understanding of the relationship between having a mental health diagnosis and suicide risk. The absence of contextual information on the specificity of what diagnoses were most prevalent and whether participants actively sought a diagnosis limits the depth of our insights. Similarly, translating abstract phenomena identified in Study 3 - such as psychological pain or emotional suppression - into measurable items for this study introduces inherent imprecision and poses limitations on the reliability of our findings. Findings must be considered in the context of these limitations.

4.6 Conclusion

Building a more nuanced understanding of potential psychosocial differences between men who are not suicidal, men who have thoughts of suicide, and men who attempt suicide is an area of critical theoretical and clinical importance. A richer insight into these different states could help develop more insightful and impactful interventions to prevent a suicide crisis from escalating. Findings from this study contribute to advancing our understanding of potential distinguishing factors as a suicidal crisis intensifies. Results broadly suggest that the factors indicated by the 3 'D' Risk model (increased emotional/psychological pain, more negative feelings and thoughts about the self, and reduced connections with others) seem important to understanding the increased risk of suicidal thoughts and behaviours in men. Particular factors associated with an increased risk of suicide attempt compared to ideation were financially struggling, having a mental health diagnosis, not being straight, having more restrictive attitudes towards emotional expression, and a reduced sense of mattering to others. Further research is required to confirm the significance of these findings, including longitudinal data collection, and prospectively monitoring potential shifts from thoughts of

suicide to planning and making an attempt in real-time as well as exploring risk factors in interaction.

Chapter 5 “Male suicide and barriers to accessing professional support: a qualitative thematic analysis”

5.1 Abstract

Objective: Male suicide rates represent a public health crisis. In almost every country, more men die by suicide than women and suicide is a leading cause of death for men worldwide. Evidence suggests that men are less likely than women to access professional support for suicidal distress. Ensuring more men access support is a critical component of suicide prevention.

Methods: This study explores responses from 725 men, worldwide, who have attempted suicide or have thoughts of suicide to an open-text question about the barriers they experience to accessing professional support. Using a thematic analysis, results reveal the multi-faceted barriers some men experience regarding undermined motivation, a lack of psychological capability, and a lack of physical and social opportunity.

Results: Findings suggest that many men have sought support but had negative experiences and that many others want help but cannot access it. Barriers include prohibitive costs and waiting times; potential costs to identity, autonomy, relationships and future life opportunities; a lack of perceived psychological capability; a lack of belief in the utility of services and a mistrust of mental health professionals.

Limitations: Like other qualitative research, the findings of this study are not generalisable and are subject to the subjective interpretations of the author team. Data sample was mainly drawn from western contexts.

Conclusion: Findings suggest the importance of examining the role of male gender in male help-seeking behaviours. We suggest 23 recommendations for services and public health messaging to increase men's help-seeking behaviours.

5.2 Introduction

Male suicide rates represent a public health crisis. In the United States, nearly 80% of suicide deaths in 2019 were male (Fowler, Kaplan, Stone, Zhou, Stevens & Simon, 2022). Similarly,

in the UK, more men have died by suicide than women each year since records began in 1861 (Seager, 2019). Understanding why men are at such a heightened risk of suicide is a critical question for researchers (Möller-Leimkühler, 2002). Men's perceived reluctance to seek professional support has been identified as contributing to the higher male suicide rate but needs closer examination (Mallon, Galway, Rondon-Sulbaran, Hughes, & Leavey, 2019). Effective help-seeking can prevent mental health challenges from escalating and protect against suicide (Addis & Mahalik, 2003; Cornally & Mccarthy, 2011; Mok et al., 2021; Reynders et al., 2015). Two systematic reviews have identified dialectical behavior therapy (DBT) and restricting access to the means of suicide as being suicide protective (D'Anci et al., 2019; Zalsman et al., 2016). Additionally, Zalsman et al. (2016), in their ten-year systematic review of suicide prevention strategies, found evidence that supports Cognitive Behavioral Therapy for reducing suicidal thoughts, lithium for reducing suicidal ideation in people with mood disorders, and valproate for people with bipolar disorder. This evidence suggests that certain therapeutic and medical interventions hold promise in reducing suicidal thoughts and behaviours. Therefore, encouraging more men to seek professional help and access these interventions could help mitigate male suicide risk.

Quantitative research suggests that men are less likely to access professional mental health support than women (Galdas et al., 2023). While not exploring suicide risk specifically, in the United States women with a mental health diagnosis are 1.6 times more likely than men to receive mental health support in a year (Wang et al., 2005). Similarly, in the UK, the 'Adult Psychiatric Morbidity Survey' found that women were 1.58 more likely to access mental health treatment than men (McManus, Bebbington, Jenkins, & Brugha, 2016). In terms of suicidal populations, Luoma et al. (2016) 40-study review found that women are more likely to be in lifetime contact with mental health services compared to men before a completed suicide. In a UK study, only 25% of people who died by suicide had contact with mental health services in the year before they died, and the people who had no contact were more likely to be male with no mental health diagnosis (Hamdi, Price, Qassem, Amin & Jones, 2008). In Tang et al.'s (2022) systematic review of 67 studies of people who died by suicide but who did not have contact with mental health services, men were consistently associated with not accessing support. Similarly, Walby et al. (2018)'s systematic review and meta-analysis showed men were significantly less likely to have had contact with mental health services than women before a suicide. This quantitative work suggests men who are suicidal seek mental health support less than women, and we urgently need to understand why.

Explanations for reduced help-seeking in men have often centred on the influence of masculine norms and social expectations for men to suppress emotions, deny pain, and cope independently (Keohane & Richardson, 2018; Kiamanesh et al., 2015; Oliffe et al., 2017; Galdas et al., 2023; Swami, Stanistreet & Payne, 2008). Scholars suggest some men may see help-seeking as a transgressive act that communicates weakness, consequently, men may fear stigma and judgement from others if they seek support (Kõlves, Kumpula & De Leo, 2013). Cultural expectations for masculinity and societal understandings of suicidal distress are not fixed or unchanging; rather, they will vary across locations and this variation will moderate how men in different environments interpret their pain and the choices they make in response to it (Connell, & Messerschmidt, 2005; Hjelmeland, 2013). Qualitative methodologies can help researchers to explore male understandings of help-seeking through their subjective perspectives and illuminate aspects of these dynamics. To this end, Hoy (2012) conducted a meta-ethnography of 51 qualitative studies exploring male perspectives on seeking support for psychological distress. While not specific to men who are suicidal, Hoy identified four barriers: 1) negative social stigma, 2) unease towards medical experts and medications, 3) challenges in expressing emotional problems, and 4) a desire to manage challenges independently. Some of these findings are supported in the relatively small qualitative literature regarding help-seeking within male suicide-specific populations. A qualitative study with 18 men in Australia suggested that some men can reject services that frame suicidal pain as a mental illness (River, 2018). Rasmussen et al. (2018) conducted a psychological autopsy study on ten suicide deaths in men aged 18 and 30 and suggested help-seeking was rejected by the men who died because it would mean not living up to familial and societal expectations, represented weakness, and a failure of personhood. Oliffe et al. (2020) study with bereaved loved ones of twenty men who died by suicide found that some men concealed their pain and never sought professional support; other men did go for help but experienced ineffectual support, primarily again because of a focus on medication, an approach rejected by men in this sample. Cleary (2017) conducted a follow-up study seven years after 52 men made a medically serious suicide attempt and found that only 20% of men accessed follow-up psychiatric aftercare, and almost half made another attempt. Cleary suggested that men doubted the effectiveness of psychiatric interventions, were reticent to disclose distress, and preferred self-medication through alcohol and drugs. Other scholars have suggested a link between a reluctance to seek professional help and some men adopting alternative coping strategies to mitigate their distress - such as alcohol and substance abuse –

which may compound some men's pain and potentially elevate suicide risk over the long term (De Leo, Cerin, Spathonis & Burgis, 2005; Keohane & Richardson, 2018). Understanding the barriers that men who are suicidal experience around accessing professional support has been identified as a critical issue for male suicide prevention (Mallon et al., 2019; Oliffe et al., 2020; Tang, 2022). Current evidence suggests that some men who are suicidal are reticent to access help, potentially because of masculine norms, while other men do seek support, but experience help that is unhelpful (Oliffe, 2020; Bennett et al., 2023; Tryggvadottir et al., 2019). The current literature on male help-seeking is relatively small, and primarily drawn from men with different mental health challenges and therefore lacks exploration of men who are suicidal specifically. The literature specific to male suicide and male help-seeking is based on quantitative methods, bereaved populations, or very small qualitative samples. Scholars have called for more qualitative work that can explore the root causes of male help-seeking reluctance and how masculine norms may impact how men recognise suicidal crises within themselves and their decisions concerning how to act on and manage their feelings of suicide (Galdas et al., 2005; Keohane & Richardson, 2018; Milner & De Leo, 2010).

This study aims to build on what is already known and qualitatively explore, across a large sample, specifically drawn from men who are currently or recently suicidal, potential barriers around accessing professional support. Like other qualitative work in this area, the rationale for this study is, as Hoy describes, "a pragmatic one" (p. 204). Building a better understanding of the obstacles men who are suicidal currently face in seeking help can inform the development of new interventions for men. By exploring barriers through a qualitative methodology, across a large sample and direct from men who are currently or recently suicidal, we hope to elicit richer data than currently available regarding the meanings, perceptions, and experiences of men who are suicidal around seeking professional support. In short, we hope these findings can help policymakers, service providers, and researchers develop interventions to increase the help-seeking behaviours of men who are suicidal.

5.2 Methods.

The data in the present study are a subset of open-text responses from the larger survey (n=3,134) reported in Chapter 4 (See 4.3 'Methods', p. 147). Ethical approval was granted by

the research ethics committee of the College of Medical, Veterinary, and Life Sciences of the University of Glasgow (application No. 200200085). All participants gave informed consent before taking part.

5.2.1 Measures

This study focused on responses to the following open-text question about professional help-seeking. Participants were initially asked: "How likely would you be to seek professional help for your mental health if you felt you needed it right now?" Participants could respond using a 3-point Likert-type scale of 'Not likely', 'Somewhat likely', 'Very likely.' Participants were then asked: "If you answered that you would not be likely what would be some of the barriers to you accessing professional support?" Participants could respond in an expanding, limitless text box.

To measure participants' past thoughts of suicide, respondents were asked 'Have you ever thought of taking your life, but not actually attempted to do so?' Participants could respond 'Yes' or 'No'. Participants who answered 'Yes', were then asked, 'When did you last think about taking your life?' Participants could answer based on a 3-point Likert-type scale of 'The past week', 'The past year', or 'Longer ago.'

To measure past suicide attempts participants were asked: 'Have you ever made an attempt to take your life?' Participants could respond 'Yes' or 'No'. Participants who answered 'Yes', were then asked, 'When did you last attempt to take your life?' Participants could answer based on a 3-point Likert-type scale of 'The past week', 'The past year', or 'Longer ago.' To measure intent participants were asked with regards to their most recent attempt, 'Which of the following statements best applies to you?' and could select either: 'My wish to die during the last suicide attempt was low; My wish to die (…) was moderate; or, My wish to die (…) was high.' Participants were also asked 'How many times have you made an attempt to take your life?'

Data were collected during the COVID-19 pandemic and questions outlined in Chapter 4 (p.146) were asked to measure the impact of the pandemic on respondents' well-being.

5.2.2 Sample and Inclusion Criteria

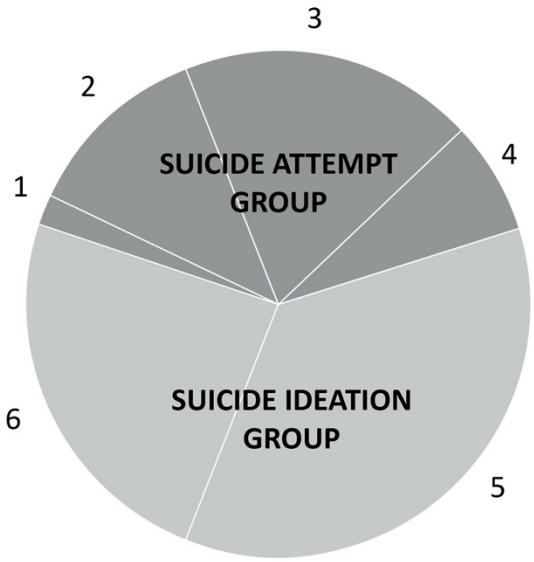
This study included men who had experienced thoughts of suicide and/or attempted suicide in the past week or year. Study inclusion and segmentation were based on the following criteria:

- Suicide Ideation Group = Participants answered 'Yes' to having thoughts of suicide within 'The past week' or 'The past year' but 'No' to suicide attempt.
- Suicide Attempt Group = Participants answered 'Yes' to a previous suicide attempt and either, 'Yes' to suicidal ideation within the last week or year, or 'Yes' to a suicide attempt within the last week or year.

5.2.3 Participant Demographics

This study comprised 725 men of whom 440 had never attempted suicide but had thoughts of suicide in the past week (*n*=264;36%), or the past year (*n*=176; 24%) (Suicide ideation group; *n*= 440; 60%); and 285 men who had attempted suicide in the past week (*n*=12;2%), the past year (*n*=84;12%) or longer ago but had thoughts of suicide in the past week (*n*=137; 19%), or the past year (*n*=52; 7%) (Suicide attempt group; *n*= 285; 40%). Of the suicide attempt group, 29% had made 1 attempt, 47% had made between 2 and 4 attempts, and 21% had made 5 or more attempts. Regarding suicidal intent, 59% stated that their wish to die during their most recent attempt was high; 32% said moderate; and 8% said low. See Figure 5.1 for an overview.

Figure 5.1 *Overview of participant's suicidal behaviours*



	Total (n)	Total (%)
Suicide Attempt Group (n = 285; 40%)		
1. Attempt this Week	12	2%
2. Attempt this Year	85	12%
3. Attempt Longer Ago; Ideation this Week	137	19%
4. Attempt Longer Ago; Ideation this Year	52	7%
Suicide Ideation Group (n= 440; 60%)		
5. Ideation this Week	264	36%
6. Ideation this Year	176	24%

Participants came from 57 different countries; however, the sample was predominately from Western locations with the highest responses - based on the United Nations classification of continents – from Northern America (40%), Northern Europe (34%), Western Europe (8%), Australia and New Zealand (5%), and Eastern Europe (3%) (United Nations, 2023). Based on the World Bank Income classifications 93% of participants were from higher-income countries, 5% from upper-middle, and 2 % from lower-middle-income countries (World Bank, 2023).

Participants were predominately aged 18-30 years (overall sample = 72%; *Ideation* = 74%; *Attempt* = 71%), white (overall sample = 78%; *Ideation* = 80%; *Attempt* = 75%), single (overall sample = 71%; *Ideation* = 73%; *Attempt* = 68%), straight (overall sample = 72%; *Ideation* = 74%; *Attempt* = 67%), employed full-time (overall sample = 38%; *Ideation* = 39%; *Attempt* = 37%), and financially doing alright (overall sample = 35%; *Ideation* = 37%; *Attempt* = 32%). Of the sample, 46% identified as having a mental health diagnosis (*Ideation* = 36%; *Attempt* = 63%). The mean impact of Covid-19 on participants was 6 out of 10 (SD = 4.99); the mean for impact on wellbeing was 6 out of 10 (SD = 5.01); and 5 out of 10 for impact on financial situation (SD = 3.46). See Appendix 5.1 for a full breakdown of participant demographics.

5.2.4 Data Analysis

This study applied a thematic analysis to the data to explore the barriers participants experienced in accessing professional support. Responses were analysed using a critical-realist, inductive thematic approach based on Braun & Clarke's (2006) methodology. Text was analysed at both a semantic and latent level for patterns of meaning across the data, as interpreted by the authors of this study (Terry et al., 2017).

Responses were downloaded into an Excel spreadsheet and coded as either 'Suicide ideation group' or 'Suicide attempt group'. All responses were read by the first author multiple times to build familiarity with the text. Basic codes that provided an initial text summary were assigned to each data point. As the ideas expressed by men in both the 'Ideation' and 'Attempt' groups were similar, responses were not analysed separately but reviewed together. Basic codes were then organised into sub-themes that cluster groups of codes together into a higher-level summary of perceived shared meanings. These sub-themes were then organised

within overarching candidate themes. This analysis stage is highly interpretative, driven by the author's perception of the deeper level of meaning within the data.

The author team constantly reviewed and reconsidered codes and themes at regular consensus meetings. Disagreements or questions were resolved by returning to the data and reflecting on its meaning (Braun & Clarke, 2006). Once coding was complete and the themes extracted, a consensus meeting was held to review the final thematic framework. During this meeting, it was suggested that the thematic framework echoed dimensions of Michie et al. (2011) behaviour change wheel (BCW). The BCW is based on insights from 19 behaviour change frameworks and stresses the importance and interaction of 1. Capability – physical and psychological; 2. Opportunity – physical and social; and 3. Motivation – reflective and automatic processes, in changing behaviours. To effectively increase male help-seeking, scholars have suggested that interventions be developed based on a theoretical understanding of behaviour change processes (Sagar-Ouriaghli et al., 2019). We wanted our work to be of maximum pragmatic utility and as such we subsequently reviewed our thematic framework against the BCW. We were able to map all the themes onto specific BCW components without losing any analytical integrity. We felt that reconceiving our framework to integrate components of the BCW would allow our findings to move beyond "merely a psychological enquiry" to "research that can actively inform the development and implementation of interventions" (Pokhrel et al., 2015, p.1). We believe this integration strengthens the practical applicability of our findings by emphasising the critical areas within the BCW where men are potentially experiencing barriers. Final agreement on the reworked thematic hierarchy and illustrative quotes were made at a consensus meeting with all authors.

5.2.5 Data Presentation

Results are organised by candidate themes along with their respective sub-themes (See Figure 5.2). Whilst themes are presented as separate domains many men reported barriers from multiple themes and the model outlined in Figure 5.2 strives to represent this dynamic interaction. Supporting quotes from respondents are used to illustrate thematic interpretations. Quotes are presented verbatim and are not corrected for spelling or grammar. Reference is made to whether the participant had thoughts of suicide or had previously attempted suicide and, where available, the recency of their ideation/attempt, number of attempts (where applicable), their current age, and location.

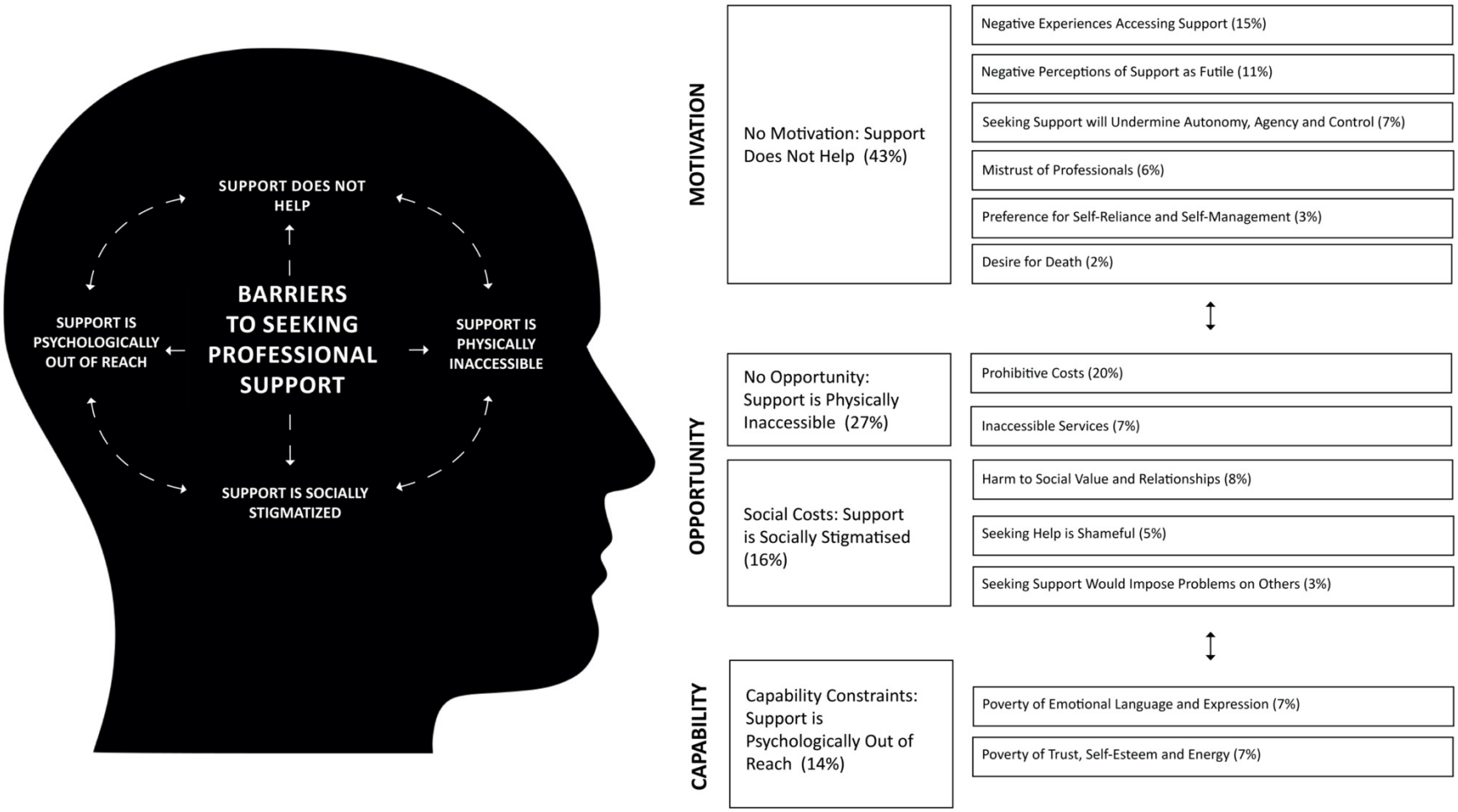
Thematic analysis is a flexible methodology with researchers invited to amend core principles to meet their own practices and processes (Braun, Clarke, & Hayfield, 2022). The purpose of a thematic analysis is not to find the most prominent meanings within a data set, but to identify the salient ones as perceived by the author team. As such, thematic analysis methodology does not require the quantification of codes. However, a degree of quantification allowed us to ground our analysis in some measure of prevalence for interpreted patterns. For each sub-theme and candidate theme, therefore, a percentage is included. This represents the percentage of codes from our analysis that suggests evidence for this theme. However, we urge caution about the interpretation of these numbers. For example, while 15% of codes from our analysis were about the sub-theme 'Negative Experiences Accessing Support' this is not representative of the actual number of men who may have had negative encounters. Participants were not directly asked that question, so the number could be higher. A sample of the supporting codes for our analysis can be reviewed in Appendix 5.2.

5.3 Results

From the analysis, 963 basic codes were generated, organised into four candidate themes (see Figure 5.2):

1. No Motivation: Support Does Not Help (43% of codes)
2. No Opportunity: Support is Physically Inaccessible (27% of codes)
3. Social Costs: Support is Socially Stigmatised (16% of codes)
4. Capability Constraints: Support is Psychologically Out of Reach (14% of codes).

Figure 5.2 *Model of Barriers to Professional Help-Seeking in Men who are Suicidal.*



5.3.1 No Motivation: Support Does Not Help

Approximately 43% of codes described men whose motivation to seek support appeared severely compromised by the belief that professional support would not be helpful. This candidate theme is broken down into six sub-themes.

5.3.1.1 Negative Experiences Accessing Support

In this sub-theme, the motivation of men to seek support was significantly undermined by past negative experiences with professional services. In the sample, approximately 15% of men reported such encounters, making negative experiences the second most prevalent sub-theme in the study. Participant responses revealed a range of negative encounters. Most men appeared to find previous help to be pointless, unhelpful, and ineffective. For a smaller group, therapy offered temporary relief, but was not beneficial over the long term. Other men suggested that the support they received amplified their feelings of suicide. Negative experiences were primarily related to doctors, therapists, and mental health professionals, although helplines and free services were also mentioned. The nature of negative encounters varied in description. Some men mentioned unpleasant experiences with therapy or medication; stigmatising, or incompetent staff; perceived anti-male attitudes and of feeling unheard or diminished; long waiting times, only being offered medication, and/or men being sectioned against their will. Some participants explicitly referenced seeking help multiple times and trying a mixture of therapeutic and medical interventions, all perceived as ineffective. These unhelpful experiences appeared to undermine men's motivation to seek support again. Some men described a loss of faith that they could be helped and of effectively giving up, resigning themselves to their psychological reality.

> "The 'barriers' are that it doesn't work. I have tried this nonsense in the past for the best part of a decade and none of it does anything for me. The problem is not with me, it is the so-called """support""" offered and how shit it is." (Ideation past week, 27, UK)
>
> "(...) all the therapists I talked to in the past told me to "men up", "grow some", downplayed my issues ("That can't be a problem for such a big boy!") or made fun of

me. I consider the profession of psychotherapy to be broken." (Ideation past week, Attempt longer ago, 2 to 4 attempts, 40, Austria)

5.3.1.2 Negative Perceptions of Support as Futile

Within the sample, 11% of men, from all income regions, and age groups, expressed sceptical beliefs about the utility of professional support. Unlike men in the previous sub-theme, this group did not explicitly reference negative past experiences but shared similar doubts about the effectiveness of available support. The reasons for their scepticism varied. Some men were suspicious of medication, doubting its effectiveness in addressing their issues. Other men didn't understand how talking about their problems could be beneficial, especially if they believed their struggles were caused by external factors like financial challenges or unchangeable biological realities, such as their perceived unattractiveness. A minority of men felt their pain was a valid response to the bleak conditions of existence and the world's brutality. Other men appeared to believe that they were beyond help and that their problems were too deep-seated or unsolvable.

"(...) In my case, you can take all the pills you want, talk for as long as you want, but ultimately, it's all a pointless exercise that doesn't alleviate the financial yoke constantly tied to your neck. It's band-aid on a gunshot would." (Ideation past week, 51, UK)

"Therapy doesn't undo abuse and make you look attractive. Complete waste of time, money and effort" (Ideation past week, Attempt longer ago, 2 to 4 attempts, 19, Australia)

5.3.1.3 Seeking Help will Undermine Autonomy, Agency, and Control

Men in this sub-theme lacked motivation to access support as they appeared to believe that doing so could impact their autonomy, agency, and control (7%). These fears related to being sectioned, forced onto medication, and/or a permanent mark placed on their health records that could impact future job opportunities.

"In Croatia, if you visit a psychiatrist using the states funds- it is permanently marked on some sort of record so future employment companies can see that you've had

psychiatric treatment, which would lead to 95% of them refusing to employ you. (...)" (Ideation past week, 21, Croatia)

"Having my agency removed from me and being placed in an institution (...)" (Ideation past week, Attempt past year, 1 attempt, 31, UK)

5.3.1.4 Mistrust of Professionals

Within the sample, 6% of men, spanning all age groups and locations, expressed doubts about the integrity, skills, and attitudes of mental health professionals. These doubts appeared to undermine some men's motivation to seek support. Some men raised questions about the motives of professionals, suggesting they were only interested in money and paid to care. Other men expressed concerns that professionals might struggle to comprehend or relate to their lived experiences, lack empathy toward the challenges faced by men, and/or only be interested in promoting medical interventions.

"(…) I feel like doctors don't really care about me or any other person, they just act caring for money or just because their profession requires so (…)" (Ideation past year, 19, USA)

"I have worked in health care for more than 30 years, and have personal knowledge of the attitudes of many HCW [Health Care Workers] to men and boys. I've experienced substantial overt misandry in many HCW, mental health providers, and particularly counsellors. [...] Why, when I need help and am at my most vulnerable, would I expose myself to such a demoralising experience." (Ideation past week, Attempt longer ago, 2 to 4 attempts, 64, Australia)

5.3.1.5 Preference for Self-Reliance and Self-Management

A minority of men, across all age groups and locations, appeared to lack motivation to seek support because they believed they could handle their mental health challenges independently (3%). Dealing with problems alone was described as cathartic or a statement of strength.

"As stubborn as it may be, I prefer to deal with my emotions on my own and find it cathartic to work through them." (Ideation past year, 21, UK)

> "I don't want anyone's help. If I can't get through my problems on my own, I'm not worth anything (…)" (Ideation past year, Attempt past year, 1 attempt, 27, USA)

5.3.1.6 Desire for Death

A small minority of men (2%) expressed no motivation to seek professional support because they did not want to get better and/or wanted to die. Suicide rather than professional support appeared to be understood as the solution to their problems.

> "When im at the point of attempt or close to i dont want to be stopped so why would i contact anybody?" (Ideation past year, Attempt past year, 2 to 4 attempts, 59, UK)

5.3.2 No Opportunity: Support is Physically Inaccessible

From the data, 27% of codes related to men who described a lack of physical opportunity to access support, broken down into 2 sub-themes. This candidate theme highlights men who may be open to professional support but experience physical barriers in accessing it. As such professional support is understood to be out of reach.

5.3.2.1 Prohibitive Costs

The most cited barriers were financial (20%). Prohibitive costs meant one-fifth of the sample experienced professional support as unaffordable. This was the most endorsed sub-theme in the study.

> "I know how bad the NHS waiting lists for therapy are My past therapy was private and I can't afford that right now. So I'll just muddle through and hope I make it" (Ideation past year, 46, UK)
>
> "In my country, this kind of help is hard to get, a good one even harder, and if you have no money, slashing your artery is a cheap and effective solution" (Ideation past week, Attempt longer ago, 1 attempt, 29, Brazil)

5.3.2.2 Inaccessible Services

Seven per cent of the sample referenced practical barriers relating to the physical inaccessibility of services. Long waiting lists, a lack of services in their area, and/or

professional support incompatible with work times were all mentioned. A few men expressed confusion around how to begin seeking professional support such as not knowing how to access it, who to call, not understanding the different pathways/therapeutic modalities, and whether services would be confidential.

> "There are no mental health providers in my insurance in my area that take appointments outside of working hours. I would have to quit my job to see them, but then would lose my insurance so I wouldn't be able to anyway." (Ideation past year, 26, USA)
> "I don't know where to go or who to talk to (...)". (Ideation past week, Attempt longer ago, 2 to 4 attempts, 18, Canada)

5.3.3 Social Costs: Support is Socially Stigmatised

Sixteen per cent of codes related to a lack of perceived social opportunity and cultural permission to access professional support, broken down into three sub-themes. This candidate theme describes men who appeared to inhabit social environments where they did not experience sufficient acceptability around help-seeking as a socially appropriate behaviour.

5.3.3.1 Harm to Social Value and Relationships

Men in this sub-theme seemed to fear the potential harm to their reputation and social standing if other people found out they had sought help (8%). Men described concerns about other people's reactions, fear of judgement, and how it could change how other people perceived and valued them and/or impact future romantic relationships. A cluster of men articulated concerns about harmful repercussions for family relationships. Some men seemed to fear that family members may be disappointed, embarrassed or think less of them. For some men, part of their pain related to family dynamics, and they were reluctant to confront these issues and make them known.

> "Cultural norms "brown people dont go to therapy"" (Ideation past year, 18, Singapore)

"(...) I may be ridiculed by my extended family because most of them have regressive attitudes towards mental health issues, despite suffering from several themselves." (Ideation past year, 18, India)

5.3.3.2 Seeking Help is Shameful

A smaller minority of men (5%) described their own shame and embarrassment as a barrier to accessing help. Men in this sub-theme appeared to believe that admitting "weakness" would mean dishonouring themselves by failing to live up to social expectations to cope alone and "get over" challenges. While some men seemed to endorse this idea, other men rejected it yet still, found themselves beholden to it.

"The admission of weakness (although my logical side understands just how stupid that is, pride gets in the way)" (Ideation past week, Attempt longer ago, 1 attempt, 33, Canada)
"Too taboo to talk about that as a man. (…) Just doing this survey makes me feel weak an is emasculating even though I strongly sympathise with men who are depressed. I would encourage men to go to therapy or get any other help because I would never judge them for that but I could never go myself." (Ideation past week, Attempt longer ago, 2 to 4 attempts, 19, Australia)

5.3.3.3 Seeking Support Would Impose Problems on Others

A minority of men (3%), all from high-income countries, and across all age groups, articulated a conceptualisation of seeking support as causing harm to others, either by burdening them with their problems, causing loved ones to worry, or occupying space in already strained health systems that might be better utilised by someone else in greater need.

"My parents may feel as if they have not done a good job raising me, or made mistakes, and I don't want them to feel that pain (...) " (Ideation past year, 18, India)
"(...) I don't want anyone to worry about me (...)" (Ideation past week, Attempt past year, 5 or more attempts, 23, USA)
"taking up resources that should be used on people more worthy or 'needy'" (Ideation past week, Attempt past year, 1 attempt, 51, Australia)

5.3.4 Capability Constraints: Support is Psychologically Out of Reach

Fourteen per cent of codes related to men who perceived themselves to lack the psychological capability to access and/or utilise professional support broken down into two sub-themes. Accessing and making use of professional support was understood to require psychological tools and resources that some men seemed to believe were beyond their reach - as such support felt psychologically inaccessible.

5.3.4.1 Poverty of Emotional Language and Expression

In the data, 7% of men described discomfort, fear, embarrassment, shame, resistance, and/or challenges around expressing their feelings. Men described not knowing how to share feelings and open up in general or specifically to a stranger/professional. Some men seemed to worry that they would be unable to express and communicate their problems effectively and that they could be misunderstood. Another small cluster of men described concerns that they may be unable to cope with confronting the reality of their emotional pain and that it may overwhelm them.

> "(...) I don't know how to put my issues into words. I always feel ridiculous when trying to phrase it, it always appears shallow and misses the mark by miles (...)" (Ideation past week, 29, Germany)
> "I don't like talking and it makes the pain so much worse so i rather bottle it up since that makes me feel a bit better" (Ideation past week, Attempt longer ago, 5 or more attempts, 20, Sweden)

5.3.4.2 Poverty of Trust, Self-Esteem, and Energy

For another cluster of men (7%) psychological barriers to accessing professional support related to a lack of confidence, low self-esteem, and feeling unworthy of help or attention; difficulties trusting others; insufficient energy to access help; and/or overwhelming social anxiety.

“I can barely brush my teeth, imagine spending 5 fucking hours trying to figure out if my insurance covers some asshole who's going to tell me to improve my diet and go for a walk (...)" (Ideation past week, 27, Canada)

“Extremely low trust in others” (Ideation past year, 24, UK)

“once again, i do not deserve my problems to be fixed. i believe i deserve to die.” (Ideation past week, Attempt past year, 2 to 4 attempts, 20, UK)

“(...) I have severe anxiety problems with going outdoors in public or to new places and I don't think I could manage it without engaging in extensive self harm to cope with the stress. (...)” (Ideation past week, Attempt longer ago, 1 attempt, 23, UK)

5.4 Discussion

Our analysis yielded four candidate themes: 1. No Motivation: Support Does Not Help (43% of codes); 2. No Opportunity: Support is Physically Inaccessible (27% of codes); 3. Social Costs: Support is Socially Stigmatised (16% of codes); and 4. Capability Constraints: Support is Psychologically Out of Reach (14% of codes). We present the candidate- and sub-themes as discrete domains. Still, it is important to note that 23% of participants expressed concerns about more than one of the four candidate themes. See Table 5.1 for illustrative quotes of interacting barriers. These multiple and interacting barriers across the four candidate themes, may reinforce and strengthen obstacles to accessing professional support.

Table 5.1 *Quotes Illustrating the Interaction of Barriers Across Candidate Themes.*

Supporting Evidence
“Finances [no opportunity], Personal Shame [social costs], Negative Experience with free services in college [no motivation].” (Ideation past week, 19, USA)
“I don't have the money to pay for something like that [no opportunity]. If my parents or anyone in my extended family found out, I think that would only make the situation worse; they are very RELIGIOUS and unbelievable HARD-HEADED. [social costs] And I don't understand how someone talking could fix the problem process [no motivation]” (Ideation past week, 21, Barbados)
“I don't trust the USA's healthcare program to protect my privacy from employers and insurance [no motivation]. I don't know who to call. I don't know how to

describe how I'm feeling [capability constraints]. I'm too broke to fix [no motivation].” (Ideation past week, 57, USA)

“1. I feel ashamed. I'm afraid someone might figure out. Nobody knows that I'm struggling and I'd prefer it to stay that way. I don't want pitty. I don't want them to change their behavior towards me just because I'm sick. [social costs] 2. Words. I don't know how to put my issues into words. I always feel ridiculous when trying to phrase it, it always appears shallow and misses the mark by miles. [capability constraints] 3. I think to a certain degree, I enjoy being suicidal, it is like having an emergency exit all the time or like a base camp you can return to when failing to get to the mountain peak. It gives me a sense of security. 4. Arrogance. I feel like I know myself best and that nobody can really help me better than I do. [no motivation] 5. Confirmation: being diagnosed solidifies the fact that one is a broken human being. Before that, I can trick myself into believing, that it might be something else, the wrong job, not enough exercise and so on...” (Ideation past week, 29, Germany)

Many of these themes, drawn from a large sample of men who are currently or recently suicidal, align with similar barriers found in existing literature exploring help-seeking barriers among men with various mental health challenges and suicide-specific research that has employed smaller qualitative samples or quantitative and psychological autopsy methodologies (Hoy, 2012; Oliffe et al., 2020; Rasmussen et al., 2018). In this discussion, we explore the potential role of masculine norms in influencing help-seeking behaviours in men who are suicidal, and the need for gender-sensitive, culturally-sensitive interventions, tailored to different age groups. We discuss how the barriers we have identified, specific to men who are suicidal, align with the domains of Capability, Opportunity, and Motivation from Michie et al.’s (2011) behavior change wheel (BCW). By mapping our findings onto an established theoretical framework for behavior change we hope to help colleagues develop more effective and targeted interventions to enhance the help-seeking behaviours of men who are suicidal. Additionally, by placing our findings in the context of previous research into the psychology of men who are suicidal, we hope to illuminate why some of these barriers are particularly relevant and concerning for a male suicide population. Our evidence suggests male help-seeking barriers must be considered in relation to the help available and whether it is accessible, appropriate, and wanted by men who are suicidal. We propose potential

recommendations for interventions, services, and public health campaigns throughout the discussion, and these are summarised in Table 5.2.

5.4.1 Masculine Norms and Male Help-Seeking

In our data, cultural norms of masculinity appeared to underpin many barriers men who are suicidal experience in their capability, opportunity, and motivation to access professional support. A poverty of psychological capability may partly be rooted in the cultural suppression of men's emotions. Social opportunities to access help may be restricted by cultural expectations for men to be strong, deny pain, and protect others. Men's motivation to access help may be affected by masculine norms of self-reliance, independence, control, and autonomy, which may lead some men to prefer to self-manage their challenges and mistrust professionals. Concerns about being medicated, hospitalised, or help-seeking negatively affecting future job and romantic opportunities, may loom large for men conditioned to be in control and successful. Talking therapy premised on articulating and exploring emotional challenges may not make sense to some men conditioned to deny their feelings.

Consequently, our findings support previous recommendations for developing gender-sensitive male suicide prevention interventions that "move beyond simplistic ideas about pathological masculinities" and engage with the multiple ways in which masculinities may interact to shape men's help-seeking (p. 2, Oliffe et al., 2020; Galdas et al., 2023). There are complicated intricacies to balance in developing male-sensitive interventions. Developing male-friendly services is not to treat men as a homogenised entity. Masculinity does not refer to fixed traits inherent to all men but to social and cultural expectations for male behaviour and these expectations will vary significantly across different social contexts, and different stages of a man's life (Connell, & Messerschmidt, 2005). Every man is an individual shaped by distinct biological, socioeconomic, political, environmental, and structural factors (Turecki et al., 2019). As such, masculinities are plural, and men are a diverse population, with intersecting identities (Coston, & Kimmel, 2012; Seidler et al., 2018). What is true for one man, i.e., the belief that getting help is weak, is not true for other men who may want support but cannot access it. Similarly, different interventions are required to both meet men in their immediate cultural conditions, i.e., develop services that support men to be self-reliant, whilst also seeking long-term cultural change, i.e., normalising men as

interdependent, relational beings who do not need to have to cope alone (Galdas et al., 2023; Sagar-Ouriaghli et al., 2018; Seidler et al., 2019). Additionally, interventions may need to work positively with masculinity to celebrate masculine strengths, while also challenging what might need to change (Galdas et al., 2023; Seidler et al., 2018), and balance helping men accept having mental health challenges without aggravating feelings of shame, failure, or loss of control (Sagar-Ouriaghli et al., 2019).

Our sample was too small to draw direct cultural comparisons. Nonetheless, across all cultural locations, prohibitive costs were the most endorsed theme, with negative past experiences also prevalent for men in upper-income, and upper-middle-income countries. For lower-middle-income countries, sceptical beliefs about the utility of support and potential social stigma were particularly prevalent. Negative past experiences were the most endorsed theme for men aged 31-50 and men 50+. For younger men aged 18-30 it was prohibitive costs. These variations in barriers among men in different cultural locations and age groups suggest targeted and tailored interventions may be required but will require further research to scope out properly. Appendix 5.3 provides a breakdown of most endorsed sub-themes by recency of suicidal behaviours, age, and location. Across all cultural settings and age brackets, men in our data experienced barriers to accessing help concerning their capability, opportunity, and motivation. In the remaining discussion, we will explore potential interventions to begin to tackle these.

5.4.2 'Motivation' Interventions

Our findings predominantly related to a lack of motivation in men who are suicidal to seek professional help. Of significant concern are the 15% of men who cited negative past experiences – the second most endorsed theme in this study. This finding resonates with previous research that some men who are suicidal <u>are</u> going for help but have bad experiences with a lack of services (Chandler, 2021), a lack of time for proper assessment (Strike et al., 2006), and an over-reliance on medical solutions (Oliffe et al., 2020; River, 2018) previously cited. This evidence suggests that professionals and public health messaging should avoid one-dimensional characterisations and understandings of men as poor/reluctant help-seekers, which may distress the many men who are suicidal who have accessed help and had negative encounters or the many men - as seen in our data - who

appear to want help but are unable to access it because of prohibitive costs or a lack of available services.

The accumulating evidence that some men who are suicidal find professional interventions ineffective, unhelpful and, at worst, damaging presents a fundamental problem for male suicide prevention. The effectiveness of encouraging male help-seeking as a suicide prevention strategy depends on available support being helpful (Seidler et al., 2018). Evidence suggests interventions like Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) help reduce suicidal behaviours, but they are not always available (Bryan, 2022) and it is not clear that they work for men (O'Connor et al., 2023). Going for help and having a negative experience may compound feelings of hopelessness and entrapment in men who are suicidal, potentially strengthening their perception of suicide as the only resolution to their pain. For example, some men in our study stated that they didn't want to access help because if they did and the help 'failed', they would have no option but to end their lives. As such, not seeking support was potentially, and paradoxically, helping to keep these men alive. This presents an ethical dilemma for the suicide prevention community. Public health campaigns may need to consider the delicate task of communicating the complex reality of seeking professional help within the current resources of many mental health systems. Is it better to prepare men for the reality that seeking support may be slow, ineffective at times, but potentially lifesaving and dissuade people of potentially unrealistic expectations that seeking support is a simple and quick process that can reduce suicide risk instantly? Additionally, as a matter of urgency, we need to identify why professional support is not working for some men who are suicidal, including conducting further research to understand their specific needs; what type of support they want and how best to deliver this (Ashfeld & Gouws, 2019; Bilsker & White, 2011; Kingerlee et al., 2019; Mahalik et al., 2012; Oliffe et al., 2020; Seidler et al., 2018; Wenger, 2011). Scholars have suggested that effective interventions for male mental health in general may need to consider how to honour some men's desire for autonomy and control, to be self-reliant and/or to manage pain privately (Hoy, 2012); using role models to share information and building on positive male traits like responsibility and strength (Sagar-Ouriaghli et al., 2018); and psychological treatments that are person-centred and collaborative (Seidler et al., 2018). Galdas et al. (2023) have developed a 5 'C' framework of co-production, cost, context, content, and communication to guide the development of masculinity in men's health (Galdas et al.,

2023). Building on these findings, we now need to understand what works specifically for men who are suicidal.

Part of this work will be about understanding how men understand the causes of their suicidal pain. Consistent with other findings, men in our data had reservations about the efficacy of medication and/or talking therapies and questioned the utility of support that did not address structural challenges, like unemployment/debt, or relationship challenges (Mallon et al., 2019; Hoy, 2012; Rasmussen, Hjelmeland, Dieserud, 2018; River, 2018). A recent review of priority actions to prevent suicide stresses the value of multimodal interventions (O'Connor et al., 2023). Our findings support this position and suggest that strengthening links between mental health services and interventions that tackle structural challenges (such as unemployment, addiction, or debt) could be important for men who are suicidal. It may also be useful to make the case to men that while strengthening emotional regulation through therapy cannot necessarily alleviate their structural challenges, it may support them in navigating these challenges more effectively.

Other men in our data, seemed to understand their suicidal pain to be a legitimate response to existence's perceived brutality and meaninglessness. Rather than medical intervention, these men may be looking for moral guidance and/or existential community. Consequently, male suicide prevention may need to situate professional support as one component within a network of potential help-seeking options that reflect how different men make sense of their suicidal pain. In coping with a suicidal crisis men may draw on help from significant others, community/peer/work support, literature, music, sport, nature, solitude, self-management tools, and others (Biong & Ravndal, 2007; Ferlatte et al., 2019). Some men may want non-medical, non-therapeutic interventions, that are more about building community bonds, interpersonal relationships, moral comfort and/or guidance to help discover meaning and purpose. Research in Ghana suggests instead of clinical professionals, religious leaders may be well positioned to provide counselling to persons in suicidal distress (Osafa et al., 2015). Given the strain on some mental health systems and the financial barriers of private support, investing in community, work, and peer support interventions as additional and/or alternative help-seeking routes for men who are suicidal may be a way to provide more immediate and acceptable forms of intervention and care. Evidence suggests all these non-medical interventions have utility for some men who are suicidal (Bennett et al., 2023; Roche et al., 2016; Struszczyk et al., 2019). Self-disclosure in these environments can reduce stress,

stigma, shame, normalise feelings, build self-acceptance, self-worth, and intimacy with others (Di Bianca & Mahalik, 2022; Ferlatte et al., 2019; Ross et al., 2016; Vatne et al., 2018). Addis & Mahalik (2003) suggest men are more likely to seek help if they can reciprocate, which may be an additional reason community and peer lead interventions are appealing for some men.

Masculine norms may also impact how professionals understand and respond to men's pain. Scholars have suggested that some professionals may lack compassion for the male experience, undermining men's confidence, and motivation to seek support (Liddon et al., 2019). Mistrust of professionals was a theme in our data, as well as past experiences of professionals perceived as lacking compassion for the male experience. Whilst we seek to encourage men to talk, we must also consider who is listening and whether they are competent to hear men's pain. Our findings support recommendations from scholars for: 1. gender-sensitive assessment and treatment plans in clinical practice; 2. modules on male socialisation and masculine norms in health-professional training programmes; and 3. tools to help professionals address their own gender bias (Mahalik et al., 2012; Seidler et al., 2019). 'Man Talk,' an intervention to increase the understanding of Samaritan volunteers of the male experience, reduced the number of short calls with men (Liddon et al., 2019). Data from our study also suggest professionals may benefit from a deeper understanding of how some men who are suicidal perceive professionals. The view some men who are suicidal hold of professionals as financially privileged, motivated by money, hostile towards men, and protected from the kinds of suffering they have endured, may impact help-seeker/help-giver dynamics. Further investigation of these views and interventions to improve professional training and compassionate ways of working with men may be useful.

5.4.3 'Opportunity' Interventions

The second component of behaviour change relates to the 'opportunity' in a person's physical and/or social environment to undertake a behaviour (Michie et al., 2011). In our data, we found evidence of barriers in both domains.

5.4.3.1 Physical Opportunity

Some men spoke of a lack of physical opportunities to access services with 27% of codes relating to prohibitive financial costs, long waiting lists, lack of service availability and time constraints, particularly when support was only available during working hours. Long waiting lists have been previously documented in the UK mental health system (Reichert & Jacobs, 2018; Punton, Dodd & McNeill, 2022). The lack of physical opportunities to access help may be particularly concerning when considering the state of mind of men who are suicidal. Feelings of hopelessness, defeat, and entrapment are theoretically implicated as drivers of suicidal despair (O'Connor & Kirtley, 2018). Knowing that private support is financially out of reach and that state mental health systems are under pressure, with limited services and long waiting lists, could compound a sense of hopelessness and entrapment for some men. A recent Delphi study to set priorities for male suicide research highlighted the urgent need to develop interventions for men who cannot afford therapy (Bennett et al., 2023). Findings here support the potential significance of this work. Digital psychoeducation programmes and tools for managing suicidal behaviours may be a low-cost solution. Digital interventions could allow men to access support immediately, within their own environments, and timeframes. Digital interventions have been identified as safe and non-confrontational tools for engaging men, particularly those who endorse masculine norms of self-reliance (Gilgoff et al., 2021; King et al., 2019). An evaluation of an Australian male suicide website featuring videos, psychoeducation materials, and profiles of male celebrities, showed it helped support help-seeking activities (King et al., 2019). Similarly, an evaluation of 'Man Therapy' an American online suicide prevention website found a statistically significant association between the website and professional help-seeking (Gilgoff et al., 2021). The success of these digital interventions in strengthening help-seeking behaviours suggests digital interventions are a medium some men engage with, and worth testing broader interventions through. As well as low-cost, digital interventions may be helpful for men experiencing social anxiety, men who mistrust professionals, men who want to self-manage a suicidal crisis, and men who want to avoid social stigma by accessing help privately and anonymously.

5.4.3.2 Social Opportunity

A lack of social opportunity was also referenced in our data. Primarily men described the stigma of others as a barrier. Participants in this study represent 57 countries and, in many locations, and communities, mental health stigma may be oppressively prevalent. Suicide prevention campaigns cannot assume that it is socially safe for all men in all environments to

admit their struggles and there may be real costs for some men of disclosing their distress (Chandler, 2021). Continued population-level public-health campaigns to change social attitudes around male help-seeking may be important and these campaigns should not only target male behaviours. Men are embedded in social networks, and the attitudes of the people around men will influence their own (Di Bianca & Mahalik, 2022). Family, community, friends, and workplaces need to normalise help-seeking and reduce social costs for men of accessing support. High-profile men and prominent cultural/community role models speaking about their mental health may also be important to help normalise help-seeking.

A small minority of men spoke of their own shame as a barrier to getting help and this accords with research that suggests social expectations for men to be strong, stoic, and suppress emotional suffering may make some men reluctant to seek help (Addis & Mahalik, 2003; Keohane & Richardson, 2018). The small endorsement of this theme (5%) suggests the social climate around normalising male distress and help-seeking may be gradually shifting though there is still work to do. Some men rejected expectations that getting help was weak and yet suggested they could not bring themselves to get support. While campaigns to normalise help-seeking in men have increased (Sagar-Ouriaghli et al., 2019), health professionals should be sensitive to a potential 'cultural lag' as entrenched norms are uprooted. New norms are not instantly adopted. Some men may be caught in the crossfire of the dissonance between old norms around 'male emotional suppression' and new cultural expectations for 'men to talk'. Residual cultural shame around getting help, and being emotionally vulnerable, suggests public health messaging, may need to work to place the centrality of emotions back in men's psyches. Like all humans, men are affective beings whose affective systems have evolved over millions of years (Damasio, 2018; Ozawa-de Silva, 2021; Lang, 1996). Understanding, processing, and managing our emotions is critical to our well-being (Barrett, 2017). Encouraging men to understand their emotional distress is not to encourage more 'feminine' behaviour but to help men reclaim a fundamental aspect of human regulation culturally denied to many. Scholars have also warned caution about the current framing of masculinity in public discourse as "toxic" which may contribute to some men perceiving social hostility towards their experiences (Ashfeld & Gouws, 2019; Seager, 2019). This may make sharing vulnerabilities - an already potentially dangerous endeavour because of transgressing masculine norms - feel even more unsafe. Similarly, the characterisation of men as the privileged sex/gender may amplify shame and failure for men struggling to cope. Increasing men's uptake of professional support may require a more

nuanced and compassionate public dialogue about the reality of the male experience in contemporary societies and how cultures may be harmful and oppressive for men (Bennett et al., 2023; Lee, & Owens, 2002).

Our findings also suggest that for men in upper-income contexts, fears of transgressing social norms of male protection may also be a barrier to men seeking support. Masculine norms that suggest men must protect others may mean some men struggle to conceive of themselves as legitimate candidates and recipients of care and concern (Seager, 2019). Our study supports previous assertions that for many people, help-seeking is an ongoing dialogue between potential harms and benefits (Addis & Mahalik, 2003; Keohane & Richardson, 2018). Men in our study described potential harms to their sense of self and social value. Wenger (2011) notes that with cancer or sexual dysfunction, men can be willing to risk help-seeking because of the perceived benefits "of survival or preserved sexual performance" (p. 6). There may be important lessons here for the suicide prevention community to re-frame help-seeking in terms that resonate with current masculine identities and foreground what a man may gain by seeking support (Farrell et al., 2016). Co-production with men who have accessed support and benefited from it could help to develop effective messages. For example, framing help-seeking as taking control of a crisis, and/or as an act of love, protection, provision, and care for loved ones who will ultimately benefit from a man feeling better and staying alive, could be effective messaging (O'Donnell & Richardson, 2018). Public health messaging could also consider how to position men as individuals deserving of support.

5.4.4 'Capability' Interventions

According to Michie et al.'s (2011) BCW model, 'capability' is central to behaviour change - people will only attempt a behaviour if they believe they can do it. Our findings suggest that some men who are suicidal feel they lack the psychological capability to access and utilise professional support. Consequently, help may seem psychologically out of reach. Men in our study expressed concerns about their ability to describe their emotions or discomfort around talking about feelings. This accords with previous evidence that suggests that men who are suicidal can experience emotional suppression, disconnection, and dysregulation (Bennett et al., 2023). Feeling unable to articulate emotional pain may make seeking help distressingly inaccessible – some men may wonder how they can be helped for something they cannot describe. Other men described a lack of self-esteem as a psychological barrier and appeared

to feel unworthy of help. This also aligns with existing evidence that suggests men who are suicidal can experience profound feelings of low self-worth and failure (Cleary, 2017; Coleman et al., 2011; Oliffe et al., 2017). Consequently, some men may believe themselves undeserving of support. Other men described a lack of trust as a psychological barrier. Again, mistrust, isolation, and interpersonal dysregulation, have all been reported in male suicide crises (Di Bianca & Mahalik, 2022; Meissner & Bantjes et al., 2017; Möller-Leimkühler, 2003). Professional help-seeking dynamics premised on trusting a stranger with intimate pain and vulnerability may feel psychologically out of reach for men who are suicidal. Other men suggested they were too 'anxious', too 'depressed', and/or lacked the energy to access support and commit to an intervention. This also accords with existing evidence that suggests men in acute suicidal pain can experience profound exhaustion, anxiety, low mood, and impaired cognitive functioning (Benson et al., 2016; Salway & Gesink, 2018). As such, men in heightened suicidal distress may feel they lack the cognitive and emotional resources to organise help and commit to it.

Taken together, this evidence underscores the potential importance of developing interventions that: 1. help men who are suicidal build their psychological capabilities; and 2. are designed based on a deep understanding of the psychology underpinning a male suicide crisis. Sagar-Ouriaghli et al. (2018) systematic review of male-specific interventions to improve men's mental health help-seeking, identified psychoeducational tools - that improve men's psychological literacy and capacity to identify and regulate symptoms - as helpful. Our data suggest these interventions may be valuably tested in male-suicide-specific populations, for whom a perceived inability to access help, may strengthen the perception of suicide as the only viable route out of pain.

Public health campaigns could also challenge men's assumptions that they lack the emotional capability to access support. Humans are sentient, emotional beings (Barrett, 2017; Ozawa-de Silva, 2021). While some men may not feel proficient in articulating the language of their emotions, they are the experience holders of them. Articulating and regulating feelings is a learnable skill that, with support, can be built further (van der Kolk, 2014). An individual man is an expert in their life and history, which is the raw material of a therapeutic intervention. Messages that problematise how men are socialised could help frame perceived psychological incapability as a consequence of the cultural suppression of men's emotions rather than as symbolic of personal failure or inadequacy (Ashfeld & Gouws, 2019; Liddon et

al., 2019). Similarly, it may be important that public health campaigns do not portray men as emotionally impaired, underdeveloped, or limited, as this characterisation may cause some men to further internalise a sense of being psychologically incapable (Seager, 2019).

Table 5.2 *Recommendations for potential interventions to support men's professional help-seeking behaviours*

Behaviour Change Domain	Barrier from Study	Proposed Intervention
Motivation	Negative Experiences Accessing Support (16%) Negative Perceptions of Support as Futile (10%) Mistrust of Professionals (7%) Seeking Support will Undermine Autonomy, Agency, and Control (6%) Preference for Self-Reliance and Self-Management (4%)	Service Design and Delivery 1. Explore the experiences of men who are suicidal of seeking help - what works and what doesn't. 2. Explore what sort of help men who are suicidal want to receive. 3. Explore the perceptions of men who are suicidal of medication and therapy; explore how men make sense of their suicidal pain; explore what language and messages are best to engage men who are suicidal around accessing support. 4. Explore designing services, and delivery systems in collaboration with male suicide lived experience experts to improve acceptability. 5. Explore multi-agency interventions i.e., structural support (debt relief, housing support) alongside psychological. Training for Professionals 6. Explore how men who are suicidal perceive professionals and how professionals perceive men, and how these views impact help-seeking behaviours and dynamics. 7. Explore training for professionals on male socialisation, masculine norms, and male suicide risk and recovery. 8. Explore male-sensitive treatment and assessment plans. Digital Interventions

		9. Explore digital interventions for men who want to self-manage their pain that help men build agency, competency, and control over their mental health and suicidal feelings. Community Interventions 10. Explore non-medical interventions i.e., community, work, peer support. Public Health Messaging: Motivation 11. Avoid campaigns that characterise men as reluctant/poor help-seekers. 12. Explore campaigns that more accurately reflect the reality of help-seeking journeys within the current resources of mental health systems. 13. Explore campaigns to help men understand different help-seeking pathways and therapeutic modalities.
Opportunity (Physical) Opportunity (Social)	Prohibitive Costs (16%) Inaccessible Services (7%) Harm to Social Value and Relationships (9%) Seeking Help is Shameful (5%) Seeking Support Would Impose Problems on Others (3%) Prohibitive Costs (16%) Inaccessible Services (7%)	Digital Interventions: Opportunity (Physical) 14. Explore digital interventions for men who are suicidal and cannot access/afford services. Public Health Messaging: Opportunity (Social) 15. Explore campaigns to challenge population-level stigma around male distress and help seeking. 16. Explore campaigns to address the potential cultural lag between old norms of ‘male emotional suppression’ and new norms for ‘men to talk’. 17. Explore high-profile men and community role models normalising seeking help. 18. Explore campaigns to reclaim the centrality of emotions and emotional regulation in the male psyche.

		19. Explore campaigns that position men as legitimate candidates for care and support.
Capability	Poverty of Emotional Language and Expression (6%) Poverty of Trust, Self-Esteem, and Energy (6%)	Suicide and Mental Health Psychoeducation Interventions 20. Explore interventions to strengthen the mental health literacy and psychological capabilities of men who are suicidal. 21. Explore how these interventions can be sensitive to the psychology of men in suicidal pain, i.e., men who may lack self-esteem and interpersonal trust; men experiencing emotional dysregulation, anxiety, and suicidal exhaustion. Public Health Messaging: Capability 22. Explore campaigns to normalise and destigmatise a perceived lack of psychological capability and problematise male emotional socialisation rather than personal inadequacy. 23. Avoid campaigns that characterise men as ‘emotionally impaired’ or ‘limited’ which may perpetuate the idea that men lack the psychological and emotional capacity to utilise professional support.

5.5.5 Limitations

Like other qualitative research, the findings from this study are not generalisable and are subject to the subjective interpretations of the author team. A different group of analysts may have developed and prioritised alternative interpretations. Additionally, many qualitative researchers reject the concept of generalisability eschewed by quantitative researchers. They don't believe that there is an external, consistent reality to what we perceive and experience that can be ‘discovered’ and used to reliably predict behaviours (Hjelmeland, 2013). Instead, qualitative researchers suggest we should view the value of qualitative work through a lens of ‘transferability’ and whether findings from a study can be meaningfully transferred and applied to other contexts or settings (Kuper et al., 2008). As such, while our findings are not universally generalizable, we believe they offer the field useful transferability.

Our sample was mainly drawn from high-income contexts, and critical factors such as race, culture, religion, and sexuality can moderate help-seeking behaviours and are not addressed directly here (Luoma et al., 2002; Nam et al., 2010). Although suicide deaths did not increase during the pandemic (Pirkis et al., 2021), data were collected during the Covid-19 pandemic, and we cannot fully account for its influence on participants' responses. Additionally, the study is based on participants' self-reported barriers towards seeking help. Consequently, responses may be influenced by subjective biases such as perceptions that help is unavailable when it is, but the participant did not identify the help. In addition, participants may have given answers that they felt were socially desirable, leading to an underrepresentation of less socially acceptable views. Our analysis was based on open-text responses to a survey question. This methodological approach helped us to reach and collect data from hundreds of men in different cultural locations. However, it is likely to have limited the depth of meaning that may be possible when using other methods. Unlike more immersive qualitative methods, such as interviews, our data does not allow for a contextualised exploration of participants' perspectives and barriers towards seeking support. Similarly, our sample was cross-sectional and as such, we were unable to explore the temporal relationship between help-seeking attitudes and suicidal behaviours. Lastly, the framing of the question may have limited the quality of insights provided. Asking men to identify 'barriers' to accessing professional support may have distorted responses depending on how men operationalized an understanding of 'barriers,' leading to potential ambiguity and variability in responses. Some men might interpret 'barriers' as structural or systemic issues, while others may associate

'barriers' with personal factors which could affect the consistency and comparability of the data. While we believe our analysis offers valuable and unique insights, like all methodologies, its findings need to be interpreted in the context of its limitations.

5.6 Conclusion

Help-seeking is a "complex decision-making process" (Cornally & Mccarthy, 2011, p. 286), and this is reflected in our findings which suggest that men who are suicidal experience multiple barriers that impact upon their professional help-seeking behaviours. Findings from our study support the broader evidence from male mental health research that incorporating a gender-sensitive approach into strategies for men's health is vital (Bennett et al., 2023; Galdas et al., 2023; Seidler et al., 2018; Seidler et al., 2019). This includes understanding how men make sense of their suicidal pain and what kind of help they want; recognising the influence of gender norms on men's help-seeking behaviours and how professionals treat and respond to men in crisis; increasing men's psychological capability to access support; integrating an understanding of masculine norms and male socialisation into professional training; creating gender-sensitive services – from the language and branding used, to the environments in which interventions are delivered – that are multi-modal and tackle both psychological and structural stressors; and integrate professional support alongside potential community, peer, and work interventions to increase physical and social opportunities for men to access effective support (Mahalik et al., 2012; Seidler et al., 2018; Seidler et al., 2019). Our study suggests that simplistic presentations of men as reluctant help-seekers undermine a complex reality and will not move us forward in developing appropriate, accessible, and appealing interventions for men. By reviewing help-seeing barriers across a large sample of men who are currently or recently suicidal and mapping these barriers onto the theoretical framework of Michie et al.'s (2011) behavior change wheel (BCW), we hope our findings can contribute to a richer, theoretical understanding from which more effective interventions can be developed. We make 23 recommendations to support this important endeavour.

Chapter 6 "Establishing Research Priorities for Investigating Male Suicide Risk and Recovery: A Modified Delphi Study with Lived Experience Experts

6.1 Abstract

Objective. This study uses the Delphi expert consensus method to work with lived-experience experts and establish research priorities to advance our understanding of male suicide risk and recovery.

Methods. Items for the Delphi were generated via findings from two recent quantitative and qualitative systematic reviews on male suicide, a comprehensive grey literature search, responses to a global survey on male suicide, and feedback from a panel of 10 international academic/clinical male suicide experts. A 2-round Delphi study was conducted to gain consensus among 242 lived-experience experts representing 34 countries on 135 potential male suicide research questions. Panellists were asked to rate each item on a 5-point Likert scale from 'should not be included' to 'essential'. Consensus was defined as 80% of respondents scoring an item as "Essential" or "Important".

Results. After 2 Delphi rounds, consensus was reached on 87 items. The final questions were then grouped by the author team and expert academic/clinical panel into thematic clusters to create a 22-point agenda of research priorities.

Limitations. Like all methodologies, there are weaknesses to the Delphi method, not least that the experts employed in a Delphi study do not represent all experts on a topic. We note that many items that did not make it to the top of the research agenda related to minority experiences. All the questions prioritised in this agenda can be applied to different demographics. However, minority populations may require tailored Delphi's using expert panels drawn specifically from those groups.

Conclusion. A final agenda of 22 research priorities was developed. Questions related to ten thematic domains: 1) Relationships with others, 2) Relationship with self, 3) Relationship with emotions, 4) Mental Health, 5) Suicidal behaviours, 6) Early life experiences, 7) Structural challenges, 8) Cultural challenges, 9) At-risk groups, and 10) Support and recovery. The three highest endorsed items related to loneliness and isolation (98%), feelings of failure (97%), and sources of stress and emotional pain (96%) for men who are suicidal.

6.2 Introduction

In almost every country, men die by suicide at higher rates than women (Aubin et al., 2013; Canetto & Cleary, 2012). Rates between sexes vary with extreme disparities in Eastern European countries, where death rates are 6 to 7 times higher for men, to relative parity in countries like Bangladesh and Pakistan (Ritchie, 2015). Not only do men die from suicide at higher rates than women, but suicide is a leading cause of death for men in many countries. In the UK, suicide is the biggest cause of death for men under 50 (Saini et al., 2020). In the USA, suicide was the sixth leading cause of death for men in 2016 (Centers for Disease Control and Prevention). Despite these alarming statistics and scale of the issue, there has only been a modest amount of research into male suicide, specifically (Bilsker & White, 2011). There is urgent and significant work to do to explore and explain men's increased vulnerability to suicide in contemporary societies and generate appropriate recovery interventions (Player et al., 2015; Swami et al., 2008).

Various explanations for men's elevated suicide risk have been proposed. Women are potentially more likely to benefit from protective factors such as acknowledging their psychological distress, seeking help, and drawing on support from their interpersonal networks (Stack, 2000). Other male-specific risk factors identified in the literature include increased substance abuse (Sher, 2020), work/financial challenges (Samaritans, 2012), shame (Kõlves et al., 2013) and experiencing sexual abuse in childhood (Schrijvers et al., 2012). Specific subpopulations of men have also been identified as at particular risk, including male sexual minorities (Canetto & Cleary, 2012), men in the military (Canetto & Cleary, 2012), rural men (Tang et al., 2022), and middle-aged men (Samaritans, 2012).

It is important to note that while suicide death rates are higher in men, women are understood to attempt more, creating a gender paradox within suicidal behaviours (Canetto and Sakinofsky, 1998). This paradox suggests that both men and women may struggle with dysregulated psychological pain and a suicidal desire, but that this distress more often manifests in death if a person is male. According to Canetto and Sakinofsky (1998), this may partly be explained by gender variation in the means used during a suicide attempt. Men are more likely to use lethal methods, such as firearms, which are not only swift in terms of point of action to outcome but have a higher likelihood of resulting in death compared to methods

more commonly used by women, such as overdosing, which may take longer to cause death allowing for a greater chance of medical intervention or a loss of intent and accessing help. Additionally, scholars suggest cultural scripts may present suicide as a fearless, forceful, and therefore 'male' behaviour which may mean suicide is more culturally and cognitively accessible for men (Canetto and Sakinofsky, 1998; Schrijvers et al., 2012; Scourfield, 2005). Critically, this cultural script may also mean male suicide attempts are underreported. Men may perceive it unmasculine to attempt and survive and therefore may not disclose previous attempts (Samaritans, 2012). While statistics around higher male death rates seem robust, Canetto & Sakinofsky (1998) suggest some caution around interpreting sex differences in suicide attempts.

6.2.1 The role of gender in male suicide

Even though suicide statistics consistently indicate a clear sex difference – with higher suicide rates in men - few researchers have asked, what is it about gendered ideas of masculinity, and their impact on male psychology, that may elevate male suicide risk (Samaritans, 2012; Seager, 2019; Swami et al., 2008)? Results from the qualitative meta-synthesis of male suicide (Study 1, Chapter 3) suggest that gender may be critical in elevating male suicide risk. Feelings of failure related to not achieving markers of male success and masculine norms to suppress emotions and interpersonal needs were all cited as potentially elevating men's psychological pain and suicide risk. These cultural harms coupled with a preference for lethal methods may explain an aspect of male suicide. The quantitative literature on male suicide has also recently been synthesised (Richardson et al., 2021) Richardson et al. (2021) drew on 105 quantitative studies and identified 68 different risk factors, including substance abuse, having a diagnosis of depression and relationship challenges such as being single or divorced.

6.2.2 Priorities for the next iteration of research

Findings from the quantitative and qualitative systematic reviews bring together significant parts of the current male suicide evidence base, consolidating what we know and highlighting future research priorities. This synthesis provides an opportunity to build on their results. Guided by their findings, we aimed to develop a research agenda to prioritise the next iteration of male suicide research. Research agendas created through independent,

decentralised, and systematic means can help maximise effective and efficient resource allocation (Iqbal et al., 2021). This is especially relevant in the mental health domain, where funding is limited (Saini et al., 2020). Research prioritisation work has increased over the last decade with the Delphi methodology often employed (Iqbal et al., 2021). Delphi studies to develop research priorities have been used across different issues, including interpersonal violence (Mikton et al., 2017), assisted dying (Rodgers et al., 2016), and a suicide and self-harm research agenda for the Northwest of England (Saini et al., 2020). To our knowledge there has been no work developing a research agenda for male suicide.

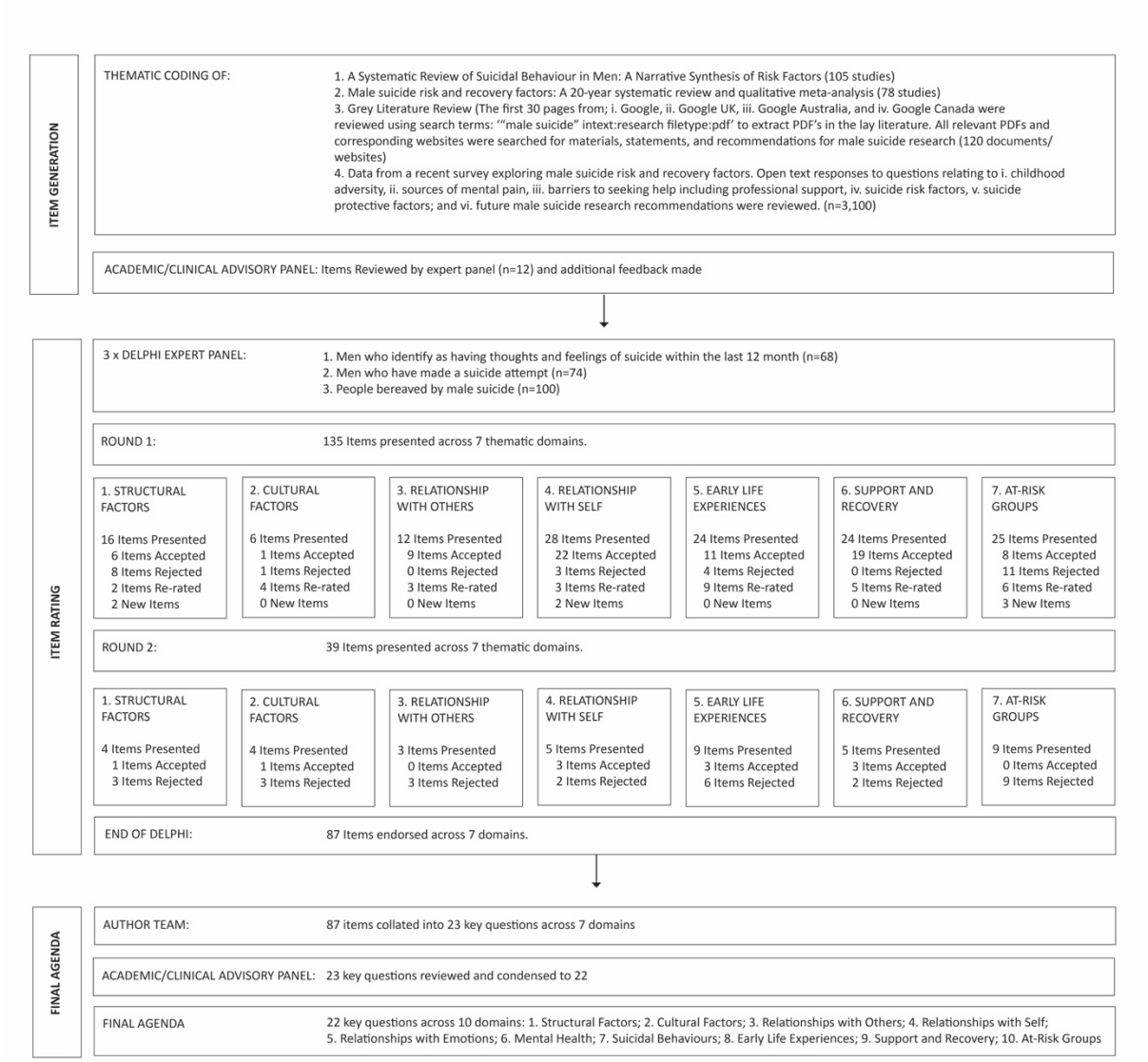
This study aims to use the Delphi expert consensus method to establish research priorities to advance our understanding of male suicide risk and recovery. A robust research agenda can ensure the most critical issues are tackled systematically, support funding bids, help identify and promote necessary collaborations, and reduce duplication.

6.3 Methods

6.3.1 Design

The design of this study was based on a modified Delphi methodology for mental health research as described in Jorm (2015). Delphi studies bring together experts on a subject, and via survey rounds, rate their agreements regarding various issues. This methodology is built on the principle that a diverse group of experts will generate better quality decisions than individuals or homogenous samples (Saini et al., 2020). Items were generated via literature reviews and survey responses. Between January 2022 and April 2022, lived experience experts rated two rounds of quantitative and qualitative survey questions (Figure 6.1). Ethical approval was granted by the College of Medical, Veterinary and Life Sciences (MVLS) at the University of Glasgow (ID 200200128). All participants gave informed consent to take part.

Figure 6.1 *Delphi consensus process*



6.3.2 Advisory Panel

For priority-setting exercises an advisory group to help guide the overall process is recommended (Viergever et al., 2010). To that end, we recruited an advisory panel (n=10) of global academic and clinical experts in male suicide to provide feedback on making sure the original and final research agenda items were robustly linked to academic literature and/or clinical practice. Panel inclusion was based on academic/clinical professionals who are leading experts in male suicide research known through the working groups' professional networks and/or experts who have authored papers on male suicide since 2000. We sought to recruit a spread of experts from different locations but were unable to secure many participants from the Global South and this is a limitation of our study. The final panel

comprised men (*n*=7) and women (*n*=3); clinical/academic experts (*n*=5) and academic experts (*n*=5); with representation from Australia (*n*=3), Canada (*n*=1), Ghana (*n*=1), Ireland (*n*=1) and UK (*n*=4).

6.3.3 Item Generation

Viergever et al. (2010) state that literature reviews and surveys of stakeholders are valuable ways to collate initial data for research setting exercises. As such, our item generation was based on collating data from three different sources. 1) Data were sourced from the two recent systematic reviews into global male suicide risk and recovery (Richardson et al., 2021; Bennett et al., 2023). 2) Grey literature was excluded from the search terms of both these reviews, and as it can be an important resource with policy and research relevant insights, a grey literature search was also conducted (Godin et al., 2015). The first 30 pages from; i. Google, ii. Google UK, iii. Google Australia, and iv. Google Canada were reviewed using search terms: '"male suicide" intext:research filetype:pdf' to extract PDFs in the lay literature. All relevant PDFs and corresponding websites were searched by the first author for materials, statements, and recommendations for male suicide research (n=120). 3) Data from a recent survey exploring male suicide risk and recovery factors (n=3,100) were reviewed by the first author for further insights. Open text responses to questions relating to i. childhood adversity, ii. sources of mental pain, iii. barriers to seeking help including professional support, iv. suicide risk factors, v. suicide protective factors; and vi. future male suicide research recommendations were reviewed. As per other Delphi studies, Braun and Clarke's (2006) thematic analysis was used by the first author to review all the data for common patterns and distil from it a set of potential research questions (Jorm, 2015). See appendices for a sample of the coding (Appendix 6.1) and the original research questions generated (Appendix 6.2). Potential research questions were developed by the first author (A1) and reviewed by Author 2 (A2) and Author (A3) in regular consensus meetings. Once a final draft of initial questions was completed this was sent to the advisory panel for feedback. Feedback from the advisory panel was reviewed by A1, A2 and A3 resulting in 135 scoring items organised into 7 thematic domains – see Figure 6.1 for breakdown.

6.3.4 Delphi Panel Recruitment

We recruited three groups of lived experience experts as our Delphi panel. There is no standard size for a Delphi panel though it is acknowledged that a higher number increases the reliability of findings (Jorm, 2015). As such we aimed for a minimum sample of 50 per lived experience group, ensuring relatively equal representation across all panels. Using a criterion sample, the three panels were: 1) Men who identify as having thoughts and feelings of suicide within the last 12 months (Suicide Ideation group); 2) Men who have made a suicide attempt (Suicide Attempt group); and 3) People bereaved by male suicide (Bereaved group). Participants were required to be aged 18 or over to be eligible. The international panel was recruited through adverts and direct emails to national mental health/suicide prevention/suicide bereavement charities; grassroots depression/male support groups; men's mental health influencers/bloggers; sports clubs; businesses with high male staff representation; social media posts/sub-threads on Reddit and the research teams personal networks. Consideration was given to target groups and organisations that represent diverse and marginalised populations including different ethnic, faith, socioeconomic and sexual minority groups. From the original approach, participants were referred to a website where they could read in full about the purpose of the study. The website included an overview of the study, a copy of the Participation Information Sheet, background about the research team and signposting to support services (Appendix 6.3). People with lived experience reviewed the website to ensure sensitivity of tone and clarity/accessibility of information. From the website, participants were able to self-select involvement in the study by submitting an online expression of interest form.

6.3.4 Delphi Process

A survey was built using online software (JISC). The survey took approximately 30 minutes to complete and included an 'Informed Consent' download document and tick box (Appendix 6.4), demographic information capture, the 135 Delphi survey items and concluded with signposting to relevant support organisations. People (n=5) with lived-experience known to the research team piloted the survey to review and test the accessibility of the survey and the language used (Hasson et al., 2000). This piloting identified that some items needed to be rephrased in more lay terms. Participants were sent an email with a link to the study and invited to rate each Delphi item based on a 5-point Likert-type scale (5 = *Essential*; 4 = *Important*; 3 = *Don't know or Depends*; 2 = *Unimportant*; 1 = *Should not be included*). At the end of each thematic set of questions was an open text box where participants were invited to

make additional comments, suggestions, and qualifications. Participants who completed the first survey were asked to participate in the second and final round and rate new items generated from open text responses in Round 1 and re-rate items from Round 1 where a consensus had not been met. Participants were provided with a PDF showing a breakdown and visual graphs of the Round 1 scoring (see Appendix 6.5 'Round 1 Scoring'). Each survey round was open for one month and participants were able to save their responses and finish their entry later. Up to three e-mail reminders were sent out to relevant participants during each round. At the start of each survey, participants were asked: "Before starting the survey please select the category most appropriate to your experience." Participants could then self-select from the following options:

- I am a man who has had thoughts/feelings of suicide over the last 12 months
- I am a man who has attempted suicide
- I have been bereaved by male suicide
- I am a man who has had thoughts/feelings of suicide over the last 12 months + I am a man who has attempted suicide
- I have been bereaved by male suicide + I am a man who has attempted suicide + I am a man who has had thoughts/feelings of suicide over the last 12 months
- I have been bereaved by male suicide + I am a man who has attempted suicide
- I have been bereaved by male suicide + I am a man who has had thoughts/feelings of suicide over the last 12 months

Originally, we only had the first three self-selection options available. However, during the piloting stage feedback suggested that people can fall across multiple categories i.e., a man may have attempted suicide and be bereaved by male suicide. To represent participants experiences accurately and sensitively it was suggested that we create options for all permeations. This self-selected categorisation was then used to organise responses for the data analysis.

6.3.5 Data Analysis

Participants were organised into reference categories of 'Suicide Attempt Group', 'Suicide Ideation Group' and 'Suicide Bereaved Group.' This categorisation was based on participants self-identification and participants were grouped in the following way:

- Suicide Attempt group = Participants who identified as: I am a man who has attempted suicide OR I am a man who has had thoughts/feelings of suicide over the last 12 months + I am a man who has attempted suicide OR I have been bereaved by male suicide + I am a man who has attempted suicide OR I have been bereaved by male suicide + I am a man who has attempted suicide + I am a man who has had thoughts/feelings of suicide over the last 12 months
- Suicide Ideation group = Participants who identified as: I am a man who has had thoughts/feelings of suicide over the last 12 months OR I have been bereaved by male suicide + I am a man who has had thoughts/feelings of suicide over the last 12 months
- Suicide Bereaved Group = Participants who identified as: I have been bereaved by male suicide

Once participants were categorised, we analysed consensus levels across the groups. Building 'consensus' is a significant tenet of the Delphi process, however there is no standard definition of what constitutes consensus and within the Delphi method researchers are encouraged to establish their own definitions and justifications (Jorm, 2015). Different practitioners have set different thresholds ranging from 51% agreement to 80% (Hasson et al., 2000). Following standards common in other suicide related Delphi studies (Lu et al., 2020), we agreed the following scoring criteria:

1. Items Accepted = Items were automatically accepted onto the research agenda if they achieved ≥80% consensus by being rated as either '5 = *Essential'* or '4 = *Important'* by <u>all</u> three expert panels ('Suicide Attempt Group', 'Suicide Ideation Group' and 'Suicide Bereaved Group')
2. Items Re-rated = Items were re-rated in Round 2 if ≥80% of 1 expert panel endorsed it as '5 = *Essential'* or '4 = *Important',* or if 70– 79.5% of 2 expert panels endorsed it as '5 = *Essential*' or '4 = *Important'*;
3. Items Rejected = Any items that did not meet the above criteria were rejected.

The quantitative survey data were analysed using R version 4.0.1. We ran descriptive statistics (i.e., frequencies) to obtain group percentages for each survey item. Open text responses were collated and reviewed by A1, A2 and A3 for any novel suggestions not already covered by existing items or improved wording of original statements (Jorm, 2015). Scoring for the final round was based solely on items that scored ≥80% consensus across all three expert panels being accepted onto the research agenda and all other items being rejected. The final endorsed items were reviewed and approved by the author team and advisory panel.

6.4 Results

6.4.1 Participant Demographics

Table 6.1 shows the demographic characteristics of the three Delphi panels. In Round 1 there were 242 participants representing 34 countries, split into three groups, Ideation (*n*=68); Attempt (*n*=74); and Bereaved (*n*=100). Round 2 was completed by 168 people, Ideation (*n*=47); Attempt (*n*=47); and Bereaved (*n*=74). There was a 68% retention rate between the two rounds, similar to other Delphi studies on suicide (Lu et al., 2020; Saini et al., 2020). The biggest drop-off was in the attempt group with a 37% attrition, 31% in the ideation group and 26% in the bereaved group. Readers should note that the final results will be skewed by an over-representation of bereaved populations who were predominately female.

6.4.2 Round 1 and 2

From the Round 1 scoring, 76/135 items met the ≥80% consensus threshold and were accepted onto the research agenda; 32 items needed to be re-rated and 27 items were rejected. Rejected items included racism and male suicide risk (61%); disability discrimination and male suicide risk (61%); homophobia/biphobia and male suicide risk (69%); exploring the relationship men who are suicidal have with food and diet (53%) and sibling abuse (68%). After reviewing the open text responses, 7 new items were generated, including questions relating to education systems, trauma, self-harm, and male suicide risk, as well as separated/divorced/widowed men, or men in insecure employment as potentially high-risk groups. Round 2 consisted of 39 items, of which 11 met the ≥80% consensus threshold, resulting in an 87-item research agenda. Two items from the open text suggestions met the

consensus - exploring trauma and male suicide risk (94%) and exploring male self-harm and suicide risk (83%). Of the original 135 Delphi items, 99% scored more than 50% consensus across the 3 panels. While not generalisable, it does suggest that recommendations in the extant academic and grey literature resonate to an extent with lived experience experts. It also suggests that many rejected items still had a relatively high consensus and could be covered as a subset of investigation within accepted items. The breakdown of the full scoring for each item is presented in Appendix 6.6 ‘Round 2 Scoring. The author team reviewed the 87 endorsed items and grouped them into further thematic clusters to make the agenda more user-friendly, resulting in 23 key questions. The advisory panel reviewed this document, and with their feedback, one question about male trauma was absorbed into a thematic cluster on male emotions, resulting in a final version of 22 priorities produced for dissemination organised into 10 thematic clusters - see Table 6.1 ‘Male Suicide Research Priorities’.

Table 6.1 *Male Suicide Research Priorities*

Theme Type	Priority Questions
Relationships with Others	1. Investigating loneliness and isolation for men who are suicidal (98%) 2. Investigating the role of meaningful interpersonal connection and intimacy in male suicide risk and recovery. *Including:* Exploring what meaningful connection means to men who are suicidal (91%), how men build connections (86%), challenges men experience creating connections (87%), the best ways to support men to create/sustain meaningful connection (89%), how meaningful connections can protect men from suicide (87%) 3. Investigating interpersonal challenges and male suicide. *Including:* Domestic abuse (physical, sexual, emotional, and/ or psychological) (88%), romantic break ups (85%), and interpersonal conflict (84%)
Relationship with Self	4. Investigating how men who are suicidal think and feel about themselves *Including:* Exploring feelings of failure in men who are suicidal (97%); Exploring the role of self-esteem (92%), purpose and meaning (92%), control and agency (83%) and self-reliance (80%) in male suicide risk/recovery; Understanding the best ways to support men who are suicidal to repair harmful thoughts and feelings about themselves (94%)
Relationship with Emotions	5. Investigating the emotional life and challenges of men who are suicidal *Including:* Exploring the main sources of stress and emotional pain for men who are suicidal (96%); Understanding how men understand, manage and express their emotions (94%), who men talk to about their emotional problems (94%), and the best way to support men to manage their emotions and emotional pain (92%); Investigating trauma and male suicide risk (94%); Surviving sexual abuse/assault (81%)
Mental Health	6. Understanding the mental health of men who are suicidal *Including:* Investigating the relationship between having a mental health condition and male suicide risk (90%); Exploring what language and messages are best to engage men who are suicidal around mental health issues (89%) and how men's mental health and suicide are represented in society and how these ideas impact men who are suicidal (86%)
Suicidal Behaviours	7. Investigating men's suicidal behaviours and coping strategies *Including:* Exploring men's suicidal thoughts and feelings (92%), how men manage thoughts of suicide and what prevents them from acting on them (91%), what suicide means to men who are suicidal (86%), what triggers a shift from thinking about suicide to planning a suicide (90%), the thought patterns and emotional states of men when planning suicidal action (90%), the past-thinking and future-thinking of men who are suicidal (90%); Exploring the attitude of men who are suicidal towards seeking help (88%) and the experiences of men who are suicidal of seeking help (93%); Exploring the coping strategies men who are suicidal use (89%) and male self-harm and suicide risk (83%)

Early Life Experiences	8. Exploring the long-term impact of early life challenges for men who are suicidal (89%) 9. Understanding the mental health of young boys who are suicidal *Including:* Exploring how mental health problems - including suicidal thoughts, feelings, and attempts - develop in young men (92%), exploring how young men seek help (i.e., talking to teachers, peers, medical professionals, chat rooms) and cope with their problems (93%) and exploring the best ways to support young men who are suicidal (95%) 10. Understanding early-life abuse/trauma and male suicide *Including:* Experiencing or witnessing psychological/emotional abuse (88%), physical/emotional neglect (88%), physical abuse (83%), and sexual abuse (81%), death by suicide of a significant other (82%), death of a significant other (85%), early life bullying (82%), family controlling behaviours, pressure and/or expectations (87%), mental health problems in the caregiving home (80%), caregiver absence, abandonment or estrangement (86%
Structural Factors	11. Investigating the role of work in male suicide risk and recovery. *Including:* Exploring the role of work stress (88%) and unemployment (84%) in male suicide risk; Understanding the importance of work as providing meaning, fulfilment and identity for men who are suicidal (81%) 12. Investigating financial challenges and male suicide risk *Including:* Exploring financial pressures and debt (90%)**,** poverty (80%), insecure housing/homelessness (80%) 13. Investigating the combined impact of multiple-structural challenges and male suicide risk i.e., being unemployed, having a disability and living in insecure housing (87%)
Cultural Factors	14. Investigating the role of masculine norms in male suicide risk and recovery *Including:* Exploring gender differences in how distress is expressed, understood, and responded to by people (86%); Exploring how men who are suicidal develop and form their ideas of masculinity (81%)
Support and Recovery	15. Exploring what 'recovery' means for men who are suicidal *Including:* Understanding how men cope after a suicide attempt (89%), what recovery means for men who have attempted suicide and men's reasons for living (88%) 16. Exploring effective interventions *Including:* Exploring the most effective support for men in the six months following a suicide attempt (85%), and the most effective long-term support (92%); Exploring the impact of different intervention types (including universal, selected, and indicated interventions, and different intervention types such as talk therapy, medication, media campaigns) (93%); Exploring how to best measure the outcome of interventions, i.e., increased self-esteem and reduced suicide risk (84%); Understanding how different services can work together better (i.e., how can the criminal justice system work with mental health care?) (84%); Exploring effective interventions for men who cannot afford / access therapy (93%) 17. Exploring the role of health-care professionals in supporting men who are suicidal *Including:* Exploring men's relationship with health-care professionals (87%) and the experiences of health service professionals of working with men who are suicidal (83%); Exploring the experience of men who are suicidal of seeking professional support (93%) and what professional support men who are suicidal want to receive (84%); Understanding what training healthcare professionals need to better identify and engage at-risk men (91%); Exploring differences in

	how men and women present suicide risk and the best gender-sensitive screening tools for health services professionals (84%); Exploring how academic researchers and health care professionals can work together to incorporate research findings into services (84%) 18. Exploring the role of significant others in supporting men who are suicidal *Including:* Exploring the experiences of men who are suicidal of seeking support from significant others (91%) and the experiences of significant others when supporting men who are suicidal (86%) 19. Exploring community interventions *Including:* Exploring how to create communities that support men who are suicidal better (84%); Exploring the experiences of men who are suicidal of accessing support in their community (83%) and the experiences of community members who support men who are suicidal (85%); Exploring effective community members who can spot and engage at-risk men (80%) and effective training for community members to support men who are suicidal (80%)
At-Risk Groups	20. Exploring men experiencing life transitions: *Including:* Young boys - 13 to 18 (82%), Male university students (84%), Middle-aged men (87%) 21. Exploring men experiencing structural challenges: *Including:* Men who are unemployed (81%); Men who are homeless (81%) 22. Exploring men experiencing emotional challenges: *Including:* Male survivors of abuse (90%); Men bereaved by suicide (83%), Men with addiction problems (83%)

6.5 Discussion

This modified Delphi study presents consensus among men who have attempted suicide, men with thoughts of suicide and people bereaved by male suicide with regards priorities for male suicide research. Here we review some of the thematic priority questions and potential directions for future research.

6.5.1 Relationships with Others

All items in this thematic domain yielded a high consensus, with 66% the lowest score. This suggests that interpersonal factors may play a significant role in male suicide. The highest rated priority across the Delphi study was 'investigating loneliness and isolation for men who are suicidal'. The high endorsement of this question (98%) accords with theories of suicide that cite interpersonal challenges and thwarted belongingness as central to suicidal pain (Leenaars, 1996; Van Orden et al., 2010). Feelings of loneliness and isolation have been strongly linked with male suicidal behaviours (Player et al., 2015; Strike et al., 2006). Isolation potentially relates to men who lack interpersonal connections and also men who have significant connections but experience challenges creating meaningful intimacy within them (Bennett et al., 2023). We need to increase our understanding of men as relational beings and explore why some men's interpersonal needs are not being met. Critical to this will be exploring priority questions concerning 'understanding meaningful connection and intimacy for men who are suicidal.' We need to explore what men who are suicidal are seeking from interpersonal dynamics and potential issues in accessing this. Other questions voted as a priority include 'investigating interpersonal challenges' specifically domestic abuse (88%), romantic break-ups (85%), and interpersonal conflict (84%). There has been very little research into understanding domestic abuse and male suicide. Future work needs to explore both men's roles and experiences as perpetrators of violence (Dewar et al., 2021) and men as victims (Powney & Graham-Kevan, 2019). By contrast, the link between male suicide and relationship breakups is well established (Samaritans, 2012; Swami et al., 2008; Whitley, 2021). We now need to deepen our understanding of why interpersonal challenges, conflict and breakups can be so painful for some men and how men can be supported to navigate these difficulties better. A question that just missed the threshold for acceptance but may be relevant to this cluster is parental alienation (79%).

6.5.2 Relationship with Self

The second most endorsed priority was exploring feelings of failure in men who are suicidal (97%). We grouped this question with other related priorities, including self-esteem (92%), purpose and meaning (92%) to explore how men who are suicidal think and feel about themselves and their lives. In the qualitative meta-synthesis, 76% of studies suggested feelings of failure were linked with increased psychological pain and suicide risk in men (Bennett et al., 2023). We need to understand why certain men are so vulnerable to overwhelming feelings of personal failure and losses in meaning.

6.5.3 Relationship with Emotions

The third highest endorsed question was exploring stress and emotional pain for men who are suicidal (96%). We grouped this with other questions such as how men understand, manage and express their emotions (94%). Male emotional suppression has been strongly linked to suicidal behaviours (Cleary, 2005; Meissner & Bantjes, 2017; Tryggvadottir, 2019) and evidenced in 92% of papers in the qualitative meta-synthesis (Bennett et al., 2023). Unbearable psychological pain is foundational to many theories of suicide (Shneidman, 1998; Soper, 2019). Our ability to regulate and manage our emotions is a core process by which we can purposefully discharge and direct psychological pain. Deepening our understanding of men as emotional beings could help us understand why some men are potentially thwarted in their efforts to do so effectively.

6.5.4 Mental Health

It is commonly held that 90% of people who die by suicide have a mental disorder (Cavanagh et al., 2003). However, the reliability of this statistic - obtained primarily through psychological autopsies - has been questioned and it is reported that men who die by suicide are less likely to have a mental health diagnosis (Fowler et al., 2022). Scholars suggest some mental health conditions which are often linked to suicide, such as anxiety and depression, may be undisclosed and/or undetected in men (Fisher et al., 2022; Kõlves et al., 2013). As such, we need to investigate the relationship between having a mental health condition and male suicide risk (90%). There is also evidence to suggest some men reject a pathologising

framing of their suicidal pain and that the bio-medical model may deter professional help-seeking (River, 2018). Instead, some men see their distress as a response to relational or structural challenges (Hoy, 2012). We need to understand how men's mental health and suicide are represented in society and how these ideas impact upon men who are suicidal (86%) and what language and messages would be most effective for engaging men (89%). These questions are particularly urgent in countries and communities where mental health stigma and criminalising laws toward suicide are still prevalent.

6.5.5 Suicidal Behaviours

This cluster of priorities relates to 'investigating men's suicidal behaviours and coping strategies.' Endorsed items such as exploring what triggers a shift from thinking about suicide to planning a suicide (90%), could help us explore potential psychological shifts in men as they transition from suicidal ideation to planning suicide to attempting suicide. This knowledge could inform the development of effective interventions to help men manage different stages of a suicidal crisis. Understanding men's coping behaviours was also a priority (89%). Evidence suggests some men may seek to anesthetise their pain through alcohol, drugs, gambling, self-harm, which can compound problems over the long-term (Andoh-Arthur et al., 2020; Meissner & Bantjes, 2017). As well as exploring potentially maladaptive coping behaviours we also need to understand adaptive coping strategies that men adopt such as social connection, sports and faith (Hoy, 2012).

6.5.6 Early life challenges

Several systematic reviews and meta-analyses have established the link between childhood challenges and suicidal behaviours (Angelakis et al., 2019; Liu et al., 2017). However, this work often uses female dominated samples and we need to better understand how childhood difficulties impact young boys and men specifically (Lemaigre & Taylor, 2019). Martin et al.'s (2004) study suggests that boy survivors of sexual abuse may be at higher risk of suicidal behaviours than girls. Prioritised questions include understanding the impact of experiencing and/or witnessing psychological/emotional abuse (88%) and early life bullying (82%). Understanding the long-term impact of early-life challenges was also endorsed as a priority (89%) as well as understanding how mental health challenges and suicidal behaviours develop in young boys (92%). Research suggests that early-life interventions such as school

awareness programmes can help reduce suicide attempts (Zalsman et al., 2016). Strengthening our understanding of how suicidal behaviours evolve and manifest in young men can help to strengthen the utility of early-life interventions and potentially prevent psychological pain from accumulating over the life course, thereby reducing suicide risk. In this work, it may be important to consider the interaction of childhood challenges and male socialisation. Men who experience trauma in childhood may experience a double jeopardy where they are exposed to psychological pain in childhood and then socialised to suppress that pain (Bennett et al., 2023). A 2013 study found that men who were abused as children and expressed high masculine norm conformity were at higher suicide risk (Easton et al., 2013).

6.5.7 Structural Factors

Three clusters of questions exploring male suicide and structural factors received priority. These questions focused on financial and work challenges, including unemployment (84%), financial pressures/debt (90%), insecure housing/homelessness (80%), and the importance of work as providing fulfilment, meaning and identity to men (81%). It is interesting to note the priority given to structural questions pertaining to men's role in economic and financial contexts and the potential importance of work and provision as continued sites of masculine meaning and identity. Previous research has shown that unemployment and job loss are more prevalent in male compared to female suicides (Whitley, 2021). When exploring this work it is important to consider the different work and financial pressures different demographics of men experience. Each man will have been afforded by his biology, environment and society, different education opportunities, aspirations and qualifications which will interact with other potential structural barriers such as race, migration status and disability, to potentially elevate suicide risk. A question that just missed the threshold for acceptance but may be relevant is exploring education systems and male suicide risk (79%).

6.5.8 Cultural Factors

Two questions about cultural factors were given priority in the research agenda. The first explores gender differences in how male distress is understood, expressed and responded to by people (86%). In terms of expression, evidence suggests, norms of emotional suppression mean some men may deny their pain - both to themselves and to others (Meissner & Bantjes,

2017; River, 2018) Other men can communicate distress in flat and/or pragmatic terms which are perceived to lack emotional urgency and so can be misread (Kunde et al., 2018; Strike et al., 2006). Thoughts of suicide can be expressed as part of light-hearted banter or after a lot of alcohol (Owen et al., 2012). Future research should explore how masculine norms contribute to how men understand, frame and express their psychological pain. In understanding male distress presentations, we also need to explore how it is responded to. Scholars have suggested that societies may be more culturally attuned and receptive to female presentations of despair (Coleman et al., 2011). Gamma bias, a term operationalised by Seager & Barry (2019), is the hypothesis that our empathy is partly conditioned by cultural norms that may mean we are more sensitive to male behaviours that cause harm than those that harm men, as well as more primed to perceive men as occupying positions of power/privilege than as being disadvantaged. These potential biases may impact upon how male distress is responded to. Understanding how men form their ideas of masculinity was also considered a priority (81%). Given consistently higher suicide rates in men we urgently need to explore the role of gender, masculine norms and male socialisation in potentially elevating male suicide risk. Previous research has shown that men who strongly endorse traditional masculine values are at higher suicide risk (Coleman et al., 2011; Coleman, 2015), particularly norms relating to self-reliance (Pirkis et al., 2017). Masculine norms were also central to findings in the male suicide qualitative meta-synthesis (Bennett et al., 2023). Future research can help us build a more nuanced understanding of how men who are suicidal develop their understandings of male behaviour, distinguishing between the cultural norms present in their area (ideologies) and their own beliefs. For example, a man may perceive cultural norms for men to emotionally suppress but reject this practice in his own behaviour. We need to explore the diversity of behaviour in individual men, amongst communities of men and across different cultures and demographics of men (Ridge, 2019; Seidler et al., 2018). At the same time, we need to continue to explore why male sex/gender as a broader, pervasive, collective identity leaves more men than women at risk of suicide (Seager & Barry, 2019).

6.5.9 Support and Recovery

We also urgently need to investigate the interventions that could help men manage suicidal crisis and access a more meaningful life. There has been limited research into what interventions work best for men (Bilsker & White, 2011). While men have traditionally been perceived as poor help seekers, growing evidence suggests men are seeking help but having

negative experiences when they do so (River, 2018; Tryggvadottir et al., 2019). We need to explore key questions such as what sort of support men want to receive (84%), and men's experiences of accessing professional support (93%).

Men are more likely than women to die on a first attempt (Jordan & McNiel, 2020) and not be in contact with mental health services (Tang et al., 2022). Given these factors, strengthening support for men through informal, non-clinical, community spaces as well as through friends and family may also be important (Schaffer et al., 2016). Significant others are often on the frontline of a loved one's suicidal crisis and are frequently an important resource for recovery journeys. However, there has been very little research to understand their experiences (Dransart & Guerry, 2017), and this was endorsed as a priority in our agenda. Similarly, evidence suggests that some men may prefer accessing support in informal community-based settings, including pubs, workplaces or sports spaces (Kõlves et al., 2013; Struszczyk et al., 2019). Again, there is a lack of research into this area and priority was given to understanding community interventions, including how to create communities that can support men who are suicidal better (84%).

The complexity of factors that contribute to suicidal pain makes the development of effective interventions extremely challenging. Indeed, the biomedical framing of suicide has been criticised for narrowing the causes of suicidal pain to a medical issue residing in the biology of the individual. This conceptualisation can limit the scope of interventions, by failing to problematise environmental, cultural and structural conditions that may be causing profound stress (Button, 2016; Hoy, 2012). We encourage researchers to explore integrated interventions that take a holistic view of men's psychological pain and a priority question that could help address this is understanding how different professional services can work together (84%). The HOPE project, for example, provides men at risk of suicide with emotional support alongside financial, work and housing support and has shown potential utility (Farr et al., 2022). Interventions to tackle social problems such as loneliness, unemployment or homelessness; raising population levels of emotional competency and interpersonal skills; media campaigns that challenge emotionally restrictive norms of masculinity could all have potential suicide prevention value. Of course, the breadth of what could be considered suicide prevention then becomes hard to boundary and evidencing the direct impact of interventions on suicide reduction may be challenging. Nevertheless, a more expansive lens on prevention may herald better outcomes and situate suicide as a

phenomenon that has roots in many facets of life beyond the individual within which the suicidal pain resides (Bryan, 2022).

Interventions may also need to be tracked over the long-term. While a man may be prevented from taking his life at the time of an intervention, he could go on to do so later. We need to take a long-term view of recovery to truly understand if suicide prevention is working and whether men require different support at different times. Intrinsic to this work will be understanding what recovery means for men who have attempted suicide and men's reasons for living, a question endorsed by 88% of participants, as well as how to best measure the outcome of interventions (84%). Developing a shared understanding of what recovery means, grounded in lived experience, and effective outcome metrics, tracked over the long-term, could help define unifying goals for what suicide prevention work is seeking to do and whether it is working.

6.5.10 Limitations

Like all methodologies, there are weaknesses to the Delphi method, not least that the experts employed do not represent all experts on a topic. However, as Jorm (2015) notes, many processes that underpin scholarship are built on a similar ethos of privileging a select group of experts' consensus on a topic. Processes such as peer- and panel reviews are all based on group decision-making and these groups will not be reflective of every expert with a relevant contribution. However, it is important to acknowledge that the priorities in this agenda are not exhaustive. In particular, we note that many items that did not make it to the top of the research agenda related to minority experiences, and we hope that the research community will take this into consideration when deciding where to put resources. For example, the suicide rates for the trans population and sexual minority men are higher than cis-gendered and heterosexual populations and, therefore, potentially of urgent priority (Hottes et al., 2016). Similarly, there has been very little research to understand the risk of suicide in men with disabilities. All the questions prioritised in this agenda can be applied to different demographics. However, minority populations may require tailored Delphi's using expert panels drawn specifically from those groups.

Similarly, the author team, advisory panel and lived experience experts come primarily from high-income, western contexts, and our results may not be relevant to other locations. We

have made all the original items available in the Appendices and we encourage researchers in other locations to develop context-specific priorities. The research team were also primarily psychologists; therefore, we brought our psychological biases to the Delphi process. Many questions from other disciplines relevant to male suicide, such as those from social anthropology, neurology, or biology, are omitted and require a different set of experts to prioritise. We welcome future considerations around how to expand and incorporate these contributions.

6.6 Conclusion

Male suicide is an urgent, under-researched and under-funded public health crisis. This modified Delphi study is the first to develop a prioritised research agenda for male suicide. This agenda highlights potential suicide risk and recovery factors related to relationships with others, relationship with self and emotions, mental health, suicidal behaviours, early life experiences, structural and cultural challenges, at-risk groups, and support and recovery interventions. The three highest endorsed questions in the Delphi related to loneliness and isolation (98%), feelings of failure (97%), and sources of stress and emotional pain for men who are suicidal (96%). These questions particularly accord with findings from the qualitative meta-synthesis on male suicide which highlighted the cultural suppression of men's interpersonal needs and emotions and failing to meet ideals of male success as potentially associated with increased suicide risk (Bennett et al., 2023). This evidence, taken together, suggests that as a first priority we urgently need to explore how men's need for connection, valued and purposeful selfhoods and emotional regulation are being met, or not, in contemporary societies.

Understanding the influence of a particular risk or recovery factor often requires focused work investigating that component. As such, many of the priorities in this agenda are singular in focus, e.g., unemployment and suicide risk. However, suicide is not caused by a single factor but by the interaction of many issues which create temporal and dynamic fluctuations in the level of risk each man faces at different moments (Whitley, 2021; Zortea et al., 2020). These priorities need to be understood and explored within the context of interacting factors and some questions might work well in combination. Multi-methods and multi-disciplinary collaborations are required to thoroughly interrogate the questions proposed in this agenda (Chandler, 2020; Hjelmeland & Knizek, 2010). People with lived experience, psychologists,

epidemiologists, sociologists, anthropologists, neuroscientists, immunologists, geneticists, political scientists, philosophers, and many others are central to addressing this research agenda. Suicide incorporates multiple aspects of human behaviour, such as emotional regulation and the neurobiology of interpersonal connections. Non-suicide specialists who are experts in these adjacent fields may be important partners for future collaboration.

This Delphi process has yielded an ambitious research agenda which we believe will facilitate progress to protect against this human tragedy. Delivering on these priorities will require significant political will, financial support, and multi-method, multi-discipline collaborations. We hope this agenda can help global colleagues to strategically target resources to deepen our understanding of the male suicide crisis, to develop effective interventions, policies, public understanding and ultimately help more men at risk of suicide to access a dignified, meaningful, and purposeful life.

Chapter 7: Discussion

7.1 Summary of Key Findings

This thesis had 4 aims: 1) To advance our understanding of the relationship between male gender, male psychology, and male suicide; 2) To explore the psychological pathways underpinning male suicide risk and recovery including potential distinctions between proximal and distal suicide risk, and between men with thoughts of suicide and men who have attempted; 3) To explore the barriers men who are suicidal experience in seeking professional support; and 4) To develop an agenda of research priorities to guide the next iteration of male suicide research. In this closing chapter the key findings from the empirical studies are reviewed, together with their theoretical implications, recommendations to support men's recovery, the strengths and limitations of the thesis, and directions for future work.

Each of the four aims is reviewed in terms of what advances were made in achieving them, their implications, and directions for future research. These findings are also summarised in Table 7.1.

Table 7.1 *Key contributions of empirical studies 1-4 to the psychological science literature*

Study	Novel Finding	Description
Study 1: Qualitative Meta-Synthesis and Systematic Review (Chapter 3)	1. Bringing together the worldwide qualitative evidence-base	Quantitative work has dominated suicidology and yielded valuable insights but can only provide an incomplete view of a behaviour as complicated as suicide. As male suicide rates continue to grow, there is an urgent need to increase our understanding of the complex dynamics at play in a male suicidal crisis. Qualitative work allows for a depth of insight that quantitative work cannot provide, yielding a rich contextualisation for how suicidal thoughts, feelings, and behaviours emerge and manifest in individual minds. As the demand for more qualitative work in suicidology increases, there is an urgent need to bring together the existing evidence base. This review synthesises key findings from existing qualitative studies, delivering a framework for what is already known, and elucidating critical directions for future research.
	2. Identifying Critical Risk and Recovery Factors	Findings suggested an association between norms of masculinity and suicide risk in 96% of the studies. Masculine norms relating to male emotional suppression, failing to meet standards of male success, and the devaluing of men's interpersonal needs were associated with some men experiencing denial, disconnection, and dysregulation within three core psychological domains: 1) emotions (92% of papers), 2) self (76% of papers), and 3) interpersonal connections (82% of papers). These processes seem to be associated with 1) increasing men's psychological pain, and 2) diminishing men's ability to regulate that pain, which we suggest elevates distal/proximal suicide risk. We speculate that the interaction and accumulation of harms across these core domains may potentially distinguish men who are suicidal from most men similarly socialised in masculine norms but who are not suicidal. Supporting men to understand and regulate emotions and suicidal pain; expanding possibilities for masculine selves; and building interpersonal connections were perceived to help support recovery from suicidal crises. The complexity of male suicide means interventions are potentially required across different levels from the individual up to the cultural domain; 22 recommendations for future male suicide research, intervention, and prevention were made.
	3.Two novel models for understanding male suicide risk and recovery	Findings were synthesised into two novel models to help better understand male suicide risk and recovery: '3 'D' Model of Masculine Norms and Male Suicide Risk' (3 'D' Risk) and '3'R' Model of Male Suicide Recovery' (3 'R' Recovery). These models are built on the reciprocal interaction between men's emotions, self-concept, interpersonal connections, and psychological pain. These models may have important clinical and conceptual implications and support clinicians, theorists, and policymakers in developing appropriate support systems for men for are suicidal.
Study 2:	1. Preliminary Support for the 3 'D' Risk Model	To advance our understanding of male suicide we need to improve our knowledge of suicidal ideation and suicide attempts as distinct yet interconnected states. By gaining insights into the psychological

Quantitative cross-sectional study (Chapter 4)		profiles of men who experience suicidal ideation distinct from men who attempt suicide, and distinct from men with no suicidal history, we can better tailor interventions to address these different states and potentially prevent loss of life. This study tested psychometric measures of phenomena/constructs identified by the '3 'D' Risk model as potentially relevant to male suicide risk to further explore their relationship in men who are not suicidal, men who have thoughts of suicide, and men who have attempted.
	2. Psychosocial differences between men with no suicidal history, men with suicidal ideation, and men who have attempted suicide	Factors that distinguished men with thoughts of suicide from men with no suicidal history were mental health diagnosis and loneliness. Factors that distinguished men who had attempted suicide from men with no suicidal history were a mental health diagnosis, sexuality (i.e., not heterosexual), and depression.
	3. Psychosocial differences between men with suicidal ideation and men who attempt suicide	Factors that distinguished men who have attempted suicide from men with thoughts of suicide were financially struggling, having a mental health diagnosis, not being straight, having more restrictive attitudes towards emotional expression, and a reduced sense of mattering to others. In particular, there has been limited research exploring general mattering and male suicide risk, and this may be a potentially valuable area of psychological exploration and intervention.
Study 3: Qualitative thematic analysis (Chapter 5)	1. Qualitative insights into the relationship between male gender and male help-seeking	Findings from this study highlight the potential importance of foregrounding male gender in research related to men's help-seeking. Restrictive and oppressive social expectations of men may potentially underpin some of the barriers men experience around accessing professional support. A poverty of psychological capability to access and utilise support may in part be rooted in the cultural suppression of men's emotions. Perceptions of help-seeking as socially transgressive is potentially related to social expectations for men to be strong, deny pain, and protect others. Men's motivation to access help may be affected by masculine norms of self-reliance that may lead some men to prefer to self-manage their challenges. Similarly, concerns about being medicated, hospitalised, or help-seeking negatively impacting future job, and romantic opportunities, may loom large in the minds of men experiencing suicidal despair who are conditioned to be in control and successful.
	2. Findings mapped to Michie et al. (2021) Behaviour Change Wheel	Thematic findings were mapped onto Michie et al.'s (2011) behaviour change wheel (BCW). The BCW is based on insights from 19 behaviour change frameworks and stresses the importance of capability, motivation, and opportunity, to changing behaviours. Understanding processes of behaviour change is critical to public health by providing potential targets for intervention. Integrating the analysis with components of the BCW may strengthen the practical applicability of findings by emphasising the critical areas within the BCW where men are potentially experiencing barriers.
	3. 23 recommendations to potentially strengthen male help-seeking	23 recommendations were made for services and public health messaging improvements to increase men's help-seeking behaviours. These include potential improvements to service design and delivery; training for professionals; non-medical interventions, and changes to public health messaging including

		avoiding one-dimensional presentations of men as poor or reluctant help-seekers and promoting men's emotionality.
Study 4: Delphi (Chapter 6)	1. Bringing together global experts and the existing evidence-base	Two recent systematic reviews have synthesised the existing quantitative and qualitative literature on male suicide. Findings from these reviews bring together significant parts of the current male suicide evidence base, consolidating what we know, and highlighting future research priorities. Guided by their findings, a comprehensive grey literature search, responses to a global survey on male suicide, and a panel of 10 international academic/clinical male suicide experts, a draft research agenda to prioritise the next iteration of male suicide research was developed.
	2. Giving voice to lived-experience experts	242 lived experience suicide experts from 34 countries, including men who have attempted suicide, men with thoughts of suicide, and people bereaved by male suicide, helped to develop the final agenda. Through a 2-round Delphi process, they endorsed items and provided feedback for the agenda.
	3. A 22-point priority research agenda	A final agenda of 22 research priorities was developed. Questions related to ten thematic domains: 1) Relationships with others, 2) Relationship with self, 3) Relationship with emotions, 4) Mental Health, 5) Suicidal behaviours, 6) Early life experiences, 7) Structural challenges, 8) Cultural challenges, 9) At-risk groups, and 10) Support and recovery. The three highest endorsed items related to loneliness and isolation (98%), feelings of failure (97%), and sources of stress and emotional pain for men who are suicidal (96%).

7.1.1 Aim 1: Understanding Male Gender, Male Psychology and Suicide

The potential impact of gendered norms on male psychology and male suicide has rarely been explored in suicidology, leaving critical gaps in our understanding. Findings from the qualitative meta-synthesis and systematic review (Study 1, Chapter 3) suggest that investigating the impact of masculine norms on male psychology may be critical to understanding male suicide. In 96% of papers, a potential association between norms of masculinity and suicide risk was identified. Masculine norms relating to male emotional suppression, failing to meet standards of male success, and the devaluing of men's interpersonal needs appeared to be associated with some men experiencing denial, disconnection, and dysregulation within three core psychological domains: 1) emotions (92% of papers), 2) self (76% of papers), and 3) interpersonal connections (82% of papers). These processes seem to 1) increase men's psychological pain, and 2) diminish men's ability to regulate that pain, which we suggest elevates distal/proximal suicide risk. The interaction and accumulation of harms across these core domains may potentially distinguish men who are suicidal from the majority of men similarly socialised in masculine norms but not suicidal. Supporting men to understand and regulate emotions and suicidal pain, expanding possibilities for masculine selves, and building meaningful interpersonal connections were perceived to help support men in recovering from a suicidal crisis. Study 1 concluded with 22 recommendations for future male suicide research and prevention and 7 recommendations for male suicide theoretical exploration. The complexity of male suicide means interventions are required across different levels from the individual to the cultural.

From Study 1, two models were developed to highlight the potential relationship between male gender, male psychology, and suicide risk and recovery: 1) Three 'D' Model of Masculine Norms and Male Suicide Risk (3 'D' Risk); and 2) Three 'R' Model of Male Suicide Recovery (3 'R' Recovery). These models are not an exhaustive summation of potential male suicide risk and recovery factors. There will be other important considerations, such as hormonal, clinical, and evolutionary aspects, that were beyond the scope of this thesis to explore. As such, findings need continued and robust exploration and interrogation. However, these models may provide a useful psychological framework to elucidate the potential relationship between male gender, male psychology, and male suicide risk and recovery.

7.1.2.1 Aim 2 Part 1: Understanding Psychological Pathways Underpinning Distal and Proximal Risk

Given its consequences, it seems logical to assume that suicide is not a behaviour easily enacted and that it is the consequence of a significant accumulation of pain. As Leenaars (1996) described, people who are suicidal have often "experienced a steady toll of life events - that is, threat, stress, failure, loss, and challenge; pain - that has undermined their ability to adjust. Suicide has a history" (p. 226). This accumulation of pain will contain contributions from distal factors, i.e., events and experiences that are not recent, though may have contributed to the psychological pain accrued over their lifetime, as well as proximal factors that are more present and central to an attempt, i.e. if a man loses his job and the distress of impending financial challenges leads to an attempt that day.

The current suicide research evidence base has been criticised for not distinguishing between distal and proximal risk factors sufficiently, leaving uncertainty about what factors may signal an impending suicide attempt (O'Connor & Nock, 2014). The only study within this thesis that examined this issue was Study 1, which utilised the 3 'D' Risk model to distinguish between potential distal and proximal risk factors. Interestingly, proximal risk factors appeared to be an intensification of dysregulation within the same psychological domains - emotions, self, and interpersonal connections - identified as distal risk factors. While further research is required to explore this relationship, there may be fundamental psychological phenomena - such as effective emotional regulation - that are critical to human well-being, and which suicide risk factors (both distal and proximal) erode. Exposure to risk factors that negatively impact functioning in these domains could increase suicide risk over time. This could suggest that differentiating between distal and proximal risk factors may not be as critical as promoting effective regulation in these core domains.

7.1.2.2 Aim 2 Part 2: Understanding Psychological Differences Between Men with Suicidal Ideation and Men Who Attempt Suicide

Alongside understanding distal and proximal risk factors is a need to develop a more nuanced understanding of potential psychosocial differences between men with no suicidal history, men who think about suicide, and men who have attempted suicide. Study 2 (Chapter 4) was

a cross-sectional study to explore these potential distinctions. Using phenomena developed in Study 1 as part of the 3 ‘D’ Risk model, the relationship between indicators of dysregulation in the domains of emotions, self, and interpersonal connections, and increased suicidality, was explored. The study also helped advance our understanding of specific psychosocial differences between men in these three groups. Overall, results supported the 3 'D' Risk model's hypothesis that dysregulation in those domains would increase as suicidal intent increased. Several factors distinguished men who had attempted suicide from men with suicidal thoughts, including financial struggles, mental health diagnosis, non-heterosexual orientation, more restrictive attitudes towards emotional expression, and a reduced sense of mattering to others. Further research is necessary to confirm the significance of these findings, including longitudinal data collection and prospective monitoring of shifts from suicidal ideation to planning and attempting suicide in real-time. Future studies should also explore the interaction of risk factors as well as mediating effects.

7.1.3 Aim 3: Understanding Barriers to Accessing Professional Support

Evidence suggests that men are less likely than women to seek professional support for suicidal distress (Schaffer et al., 2016). Ensuring more men access help is a critical component of suicide prevention, as effective professional interventions can potentially prevent a suicidal crisis from escalating. Given the pragmatic focus of this thesis, it felt a priority to investigate the obstacles that hinder men from seeking professional assistance. The literature concerning men's help-seeking for psychological problems is recent and primarily quantitative. Many scholars have highlighted the urgent need for more qualitative work to investigate the root causes of men's help-seeking reluctance (Galdas et al., 2005). Findings from Study 3, a qualitative empirical study, indicate that restrictive and oppressive social expectations of men may underpin some of the barriers men experience around accessing professional support. A poverty of psychological capability to access and utilise support - including a lack of trust in others and/or ability to articulate emotions - may partly be rooted in the cultural suppression of men's emotions. Some men’s perceptions of help-seeking as socially transgressive may relate to social expectations for men to be strong, deny pain, and protect others. These cultural ideas may affect men's ability to understand themselves as legitimate candidates for support. Men's motivation to access help may be impacted by masculine norms of self-reliance that may lead some men to prefer to self-manage their

challenges. Similarly, concerns about being medicated, hospitalised, or help-seeking negatively impacting future job and/or romantic opportunities may undermine men's motivation to get help. Perceived harmful consequences to men's autonomy and agency may contradict and threaten men's ability to fulfil social expectations of male success and control. As Chandler (2021) noted, it is crucial to acknowledge that some men still may face substantial social consequences for deviating from masculine norms and expressing distress. Within these complex cultural contexts, messages that stigmatise men for not seeking support may undermine the nuanced realities at play. Men's attitudes to seeking help in lower-income contexts also requires further exploration, especially in consideration of what sources and avenues for help may be available in these environments. Study 3 concluded with 23 recommendations to improve men's uptake of services. Results suggest interventions should target changing both men's behaviours and those of wider actors including services, professionals, communities, families, workplaces, and societies to make support accessible and appropriate for men.

7.1.4 Aim 4: Developing Male Suicide Research Priorities

Findings from Studies 1, 2, and 3 identified multiple critical areas for future investigation. It felt important to distil the most important priorities to help direct the next iteration of male suicide research work. Study 4 brought together 242 lived experience experts and a panel of 10 leading academic and clinical male suicide experts to develop an agenda of priorities for male suicide research. A final agenda was produced with 22 key questions relating to ten domains: 1) Relationships with others, 2) Relationship with self, 3) Relationship with emotions, 4) Mental health, 5) Suicidal behaviours, 6) Early life experiences, 7) Structural challenges, 8) Cultural challenges, 9) At-risk groups, and 10) Support and recovery. From this study, the three questions that received the highest endorsement concerned male loneliness and isolation (98%), feelings of failure (97%), and sources of stress and emotional pain for men who are suicidal (96%). These findings accord with the psychological phenomena of interpersonal connections, self, and emotions identified in the 3 'D' model (Study 1) as potentially underpinning male suicide risk.

7.2 Theoretical Implications

In the introduction, key psychological phenomena identified by theories of suicide as important were reviewed. These included: 1) psychological pain and tools to regulate it; 2) specific emotional states such as hopelessness and entrapment; 3) feelings and thoughts about self, i.e., negative self-awareness, unlovability, perceived burdensomeness, and 4) connections with others i.e., thwarted belongingness, loneliness, absence of caring connections. A key theoretical question for this thesis was understanding if, and how, these theories may relate to the crisis of male suicide. In Study 1, based on findings from the qualitative meta-synthesis, 7 recommendations for future theoretical exploration were made, which has been expanded to 8 to include exploring cultural evolutionary contexts and collated in Appendix 7.1. These recommendations include disentangling the impact of psychological pain on male suicide risk from physical pain and integrating emotional regulation, feelings of failure, and childhood challenges into theories of male suicide. Additionally, the need for theories of male suicide to take both a cultural and evolutionary perspective is emphasised, the importance of which will be explored in more detail now.

7.2.1 Culture and Theories of Suicide

The explicit role of culture is absent from leading psychological suicide theories. Findings from this thesis suggest it is theoretically significant as norms of masculinity appear critical to men's exposure to and regulation of psychological pain.

Why should culture be important to understanding male suicide? Culture is a powerful tool for organising and regulating behaviour. In this thesis Sapolsky's (2017) definition of culture as "how we do and think about things, transmitted by nongenetic means" (p. 279) has been used. Cultures set expectations around how people should behave, and these behavioural templates can expand and limit people's sense of possibilities (Mueller, Abrutyn, Pescosolido & Diefendorf, 2021). Most humans live in some level of kinship and connection with others. As social creatures, our wellbeing and psychological safety, is often dependent on our ability to create and sustain relationships that keep us socially accepted, safe, and secure. Consequently, meeting the behavioural expectations of our social worlds can be critical for our social safety and can create a strong need within individuals to regulate their behaviour by conforming to some extent with the prevailing cultural norms. Research to indicate that pain networks are activated in incidents of psychological pain suggests that at a certain point, it potentially became advantageous for humans to be as sensitive to potential cues of social

unsafety through social pain responses, as it was to feel pain in response to incidents of physical harm (Eisenberger & Lieberman, 2004).

Cultural scripts exist externally, i.e., in institutions, advertising, media, representation, films, and songs; cultural scripts are also internalised and inform people's schemas about themselves, such as how they should behave, what others expect of them, what to care about, what behaviours have social value, and which are socially transgressive (Hjelmeland, 2012). Cultures can mould our sense of self, informing our ideas about who we should strive to be in the world, our beliefs about whether we are succeeding or failing, our self-esteem, sense of agency and competency (Arnault, 2009; Heine, 2007). Cultures impact upon our relationships with others creating dictates around how we interact with one another, whom we should value and trust, how we should behave in relation to one another, how we build intimacy and authenticity in our interpersonal dynamics. Similarly, cultures can impact our emotions. Emotions are biological phenomena, modified and mediated by culture (Barrett, 2017). All humans are in a perpetual state of feeling - we constantly feel something - and so feeling is an essential component of existence (Damasio, 2021). This biological, qualitative state gets wired to cultural settings that impose different emotional scripts to these feelings, applying different meaning-labels to define emotions, and different rules about who can feel what, when, why, and how we feel (Mesquita, 2022). Many cultures have words for emotions that are wordless and invisible in other cultures.

Societies often have different social scripts regarding expectations for male and female behaviour (Hochschild, 1983). Men and women may feel a profound pressure to conform to these norms to attain social acceptance, safety, and status. In this thesis, men's relationships with their emotions, self, and others were partly defined by the permissions, possibilities, and limitations of cultural norms relating to acceptable and appropriate behaviour for men within these domains. Certain cultural norms appeared to be associated with men who are suicidal experiencing poor emotional regulation and dysregulated ideas of self and interpersonal connections. The combination and interaction of the harmful and limiting consequences of these norms may mean some men are exposed to high levels of psychological pain coupled with less effective tools to regulate that pain, potentially increasing suicide risk.

Cultural norms of masculinity may also help explain the gender paradox in suicide (Canetto & Sakinofsky, 1998). Findings from Study 1 found that denial, disconnection, and

dysregulation of emotions, self, and interpersonal connections were present in studies that included female and male participants. While this study was not designed to be comparative between genders, our findings suggest that the relationships people who are suicidal have with their emotions, self, and others may underpin suicidal pain - irrespective of gender. Cultural norms of masculinity may increase men's baseline risk in certain locations where men are potentially given cultural scripts that can lead to increased denial, disconnection, and dysregulation in these domains. Cultural norms differ worldwide. As such, it is reasonable to hypothesise that cultures with gendered scripts that constrain a gender's regulation of emotion, self, and/or connection with others could increase that gender's suicide risk. For example, research from rural China has indicated that certain cultural norms mean some women are less likely to express their feelings and have fewer interpersonal connections, which has been linked to female suicides (Sun & Zhang, 2019). An essential part of understanding suicide risk may be to ask how specific cultural contexts impact upon how people learn to connect with and regulate their emotions, self-concept, and relationships with others. What cultural permissions are people afforded in these domains? Findings from this thesis are not intended to suggest that there are innate psychological differences between men and women - this may be true but cannot be ascertained from the evidence here. Instead, findings from this thesis suggest that cultural factors may potentially affect how different genders connect with and regulate certain psychological phenomena. Male and female psychological clay may be the same, but cultures sculpt this clay uniquely according to gendered ideas of what is appropriate and expected of men and women. This sculpting can create specific strengths and weaknesses in each gender's psychological form. For example, the cultural suppression of men's emotions may weaken some men's psychological capacities to regulate their emotions effectively. Integrating an understanding of how cultural norms may impact a person's connection and relationship with psychological phenomena identified as critical in theories of suicide, could help expand our understanding of a person's risk exposure.

7.2.2 Evolution and Theories of Suicide

Considering the severity of suicide, it is crucial to understand why certain risk factors could be so distressing that they lead to the decision to end one's life. For example, why would thwarted belongingness and perceived burdensomeness, proposed by Joiner (2005) as drivers of suicide, be so painful that death could seem preferable to enduring these states? An

evolutionary perspective may help explain why certain psychological states are so essential to human well-being that dysregulation in these domains could lead to suicidal behaviours. This thesis proposes that dysregulation of emotions, self, and connections with others may increase men's suicide risk by exposing them to psychological pain and undermining their ability to regulate it. As discussed in Chapter 3, future theoretical work exploring the evolutionary significance of these domains could advance our understanding of why suicide may arise in response to their disruption.

Both Gunn (2017) and Soper (2018) proposed theories of suicide that explore the evolutionary importance of psychological pain. Their theories build on evidence to suggest that neural pathways activated during the experience of physical pain are also active during conditions of social pain. They proposed that as social safety became more critical to human survival, the biological pain system may have been 'co-opted' by psychological pain. The decision to end one's life suggests that a person's psychological pain is so intense, and options to alleviate it so exhausted, that suicide is perceived as the only way to end the pain. This theoretical relationship between the evolution of psychological pain and suicide is speculative but does start to offer a potential explanation as to why and how psychological pain can become fatal. It may also imply that our relationship with our emotions, self, and connections with others could also be critical from an evolutionary standpoint because of their relationship and interaction with psychological pain.

Starting with our connections, if psychological pain evolved to help to keep us socially safe by using social pain to signify when we may be in social danger, this hypothesis implies that dysregulation in our connections with others could cause significant psychological distress. Male gender role socialisation could leave some men socially isolated and lonely. In this way cultural norms may be harming some men's ability to fulfil an evolutionary need for meaningful interpersonal connection.

Similarly, and as already discussed, psychological pain is partly an emotional state. It feels like something to be in pain; those feelings are often unpleasant and can help motivate an organism to do something to stop them. Identifying, understanding, and managing emotions is potentially an essential aspect of regulating psychological pain and transforming it into something less painful. While effective emotional regulation may serve multiple evolutionary functions, helping to regulate psychological pain and maintain social safety and survival, may

be a critical one. For example, if it didn't feel like something to be rejected, or lonely, humans may lack the necessary motivation to regulate their behaviour in service of maintaining connections with others. This could potentially lead us to become dangerously isolated and undermine our ability to survive. Our emotions may have helped human survival by providing us with a mechanism by which we can regulate our behaviour in service of maintaining social safety. Dysregulation of emotions could potentially undermine a vital evolutionary system of human functioning.

At some point in history, the human selfhood evolved - an awareness that we are individuals, separate and distinct from others. This awareness has an affective quality. People have feelings about themselves. These feelings can vary - we might be proud of aspects of ourselves and deeply ashamed of other parts. For most people, their sense of self exists in their own mind and they are also aware that they exist in the minds of others. In other words, we know that other people can have thoughts and feelings about us. Why did the human selfhood evolve? How was it evolutionarily helpful? Some scholars suggest that the development of human selfhood may have given us an evolutionary advantage by imbuing our lives with a sense of agency which has helped us more effectively plan and direct our behaviours (Stevens, 1996). Being an effective individual within a social unit could also help enhance an individual's psychological safety. Successful selves are often socially and culturally valued; being an effective individual could increase a person's status and importance to the collective. In turn, having a negative sense of self, low self-esteem, a sense of limited personal agency and competency, and feeling like a failure could suggest social unsafety and be psychologically painful to endure. From an evolutionary perspective, dysregulated feelings of self could, therefore, potentially undermine another core aspect of human functioning and flourishing.

These ideas are speculative and require much more rigorous investigation. There will be many potential factors for the evolutionary value of human emotions, selfhood, and connections with others. This brief sketch of potential theoretical links illustrates the potential symbiotic functions of these domains to human well-being and how their dysregulation may be related to suicide. Understanding, from an evolutionary perspective, why effective regulation of emotions, self, and connection with others, may be so important to human functioning, could help explain why dysregulation in these domains may contribute to one of the most extreme human behaviours - suicide.

7.2.3 Cultural Evolution and Theories of Suicide

Our bodies have an evolutionary history and so do our cultures (Sloan Wilson, 2019). Cultural ideas, values, beliefs, and practices develop and change over time (Damasio, 2021). Combining an evolutionary perspective with a cultural one, could potentially deepen our understanding of suicide risk even further. For example, suppose humans have an evolutionary human need for social connection and lacking it can be a source of psychological pain that may increase suicide risk. In that case, dysregulation of connections with others is potentially a universal suicide risk, from an evolutionary point of view. We can then apply this knowledge to specific cultural conditions and problematise how they might expose certain people to a higher risk of dysregulation in this domain. For example, in societies where masculine norms encourage men to be autonomous and independent, we can begin to hypothesise how cultural forces may put men at a higher baseline risk in terms of meeting evolutionary needs for connection which could increase their exposure to psychological pain and suicide risk.

Similarly, understanding the cultural evolution of phenomena relevant to suicide theories may also be important in understanding why certain ideas and beliefs may have culturally prevailed, and what benefits they may have brought the collective. Again, this work is speculative – cultures do not leave a manual explaining their evolution. However, exploring how and why cultural ideas relevant to suicide phenomena emerged could strengthen our theoretical understandings. For example, charting the cultural emergence of ideas of male emotional suppression may help bring into focus some of the pressures from the collective for men to adhere to this behaviour. Some scholars have suggested that a cultural expectation for men to suppress aspects of their emotions can be linked to the rise of capitalism, dangerous industry, and world wars (Ashfeld & Gouws, 2019; Seager, 2019). Bernard (1981) suggests that the evolution of the "provider" as a role assigned specifically to men happened as societies shifted away from subsistence economies to money-based market ones. These new economies relied on heavy industry which led to a gendered division of labour with high-risk professions and environments such as mining and construction becoming masculine sites, as women often took on the cultural role of homemakers (Bernard, 1981; Bolster, & Berzengi, 2019). Scholars have suggested that undertaking dangerous, high-risk work, or fighting in wars, may have necessitated men to emotionally suppress. If your job carries a daily risk of

death, you potentially need to emotionally disassociate and shut down in order to carry out such work (Ashfeld & Gouws, 2019; Seager, 2019). Similarly, suppressing men's needs for intimacy and connection may have been required in order for men to meet goals of financial provision that would demand their time and presence in sites of work rather than in family and community spaces. As a cultural focus on men as providers, enacted in professional domains, ascended, men's social value may have been increasingly tied to workplace achievements to the potential detriment of men undertaking nurturing, intimate, relational, and community roles (Ashfeld & Gouws, 2019; Bernard, 1981; Brown, 2019). The social demarcation of male value tied to work and provision may also give men strong cognitive and emotional representations of what constitutes a successful man of social value versus a failed man (Coleman, Kaplan, & Casey, 2011; Möller-Leimkühler, 2003). This contextualisation of the cultural history of male emotional suppression requires much more interrogation, but these suggestions reveal some of the ways in which societies may have materially prospered from perpetuating this norm and its impact on men's interpersonal connections and selfhood. Exploring culture as an evolutionary process can potentially yield richer insights into male suicide risk helping us understand how cultural changes may have impacted male identity and some of the cultural roots of male social value and social pain.

7.2.4 Theoretical Interactions

As previously stated, the phenomenon identified in this thesis as potentially critical to suicide should not be considered in isolation but in dynamic interaction. The regulation of psychological pain, emotions, self, and connections with others are intertwined. For example, people with poor emotional regulation skills may be prone to shutdown or outbursts because they struggle to identify, manage or express their emotions effectively. This can impact their ability to function within the demands of their daily lives, impacting their self-esteem, and/or their ability to build and sustain intimate connections with others. Similarly, our thoughts and feelings towards ourselves are impacted by our connection with others. Our self-esteem is often, partly rooted, in mattering to others and being valued by them (Elliott et al., 2005). People who are socially isolated, or unable to build emotional connections in their relationships, may feel a sense of failure. In a myriad of complex ways, regulation of emotions, self, and connection with others may be interlinked. As such, these domains may represent psychological tectonic plates that underpin core aspects of human functioning, similar to how tectonic plates are the foundation of the earth's crust. Above the tectonic

plates of the earth, extremely diverse cultures and societies exist. Similarly, above these psychological tectonic plates very different lives may exist. As such, suicide can happen to men whose lives objectively look very different but who have similarly developed dysregulation within these core, psychological, tectonic plates. Shifts in one plate i.e., emotions, may trigger shifts in other plates i.e., feelings towards self and/or connections with others. Dysregulation in these domains could contribute to internal instability and unbearable psychological pain and suicide risk. Each man who is suicidal will have his own unique relationship with his emotions, self, and connections with others shaped by his biological makeup, lived experience, and cultural contexts. Understanding suicide risk may be about understanding how an individual regulates these core tectonic plates and what skills they need to regulate them more effectively.

7.3 Recommendations for Male Suicide Research, Prevention, and Intervention

Each empirical study in this thesis concluded with recommendations for future suicide research, intervention, and prevention. In total, there are 60 recommendations summarised in Appendix 7.2 that encompass a range of recommendations from men-at-risk to population-level changes. For men at risk of suicide, recommendations include further research to understand risk factors relating to men's relationship with self, emotions, suicidal behaviours, mental health, connections with others, early life experiences, as well as structural and cultural challenges. Recommendations to improve services include training for health professionals in masculine norms, male psychology and suicide risk, and the development of gender-sensitive services that take into account how men make sense of their suicidal pain and how men want to be supported. This will potentially involve increasing support via non-clinical routes, including community, peer, and work interventions, and additional support for significant others caring for men in suicidal crisis. Recommendations are also made at the universal level via more gender-sensitive public health messaging, psychoeducation and richer representations of masculinity in the public sphere. There is significant work to do on multiple fronts that will require considerable political will, financial resources, and multi-partner, collaborative, long-term partnerships to tackle. In terms of prioritising next steps, findings from Study 4 suggest that the three priorities for research relate to loneliness and

isolation (98%), feelings of failure (97%), and sources of stress and emotional pain for men who are suicidal (96%).

7.3.1 Exploring Cultural Constructions of Masculinity

Research exploring cultural influences and male suicide risk requires nuance and balance. There is no singular way to be a man (Struszczyk et al., 2019). Norms of masculinity are expansive, dynamic, and eclectic, and different 'masculine' characteristics are afforded different social value at different times by different communities (Anderson, 2009; Chandler, 2012; Seidler et al., 2018). Men in different cultural settings will absorb, embody, and reject different messages with regard to socially valued male behaviour. Effective male suicide research needs to be mindful of the diverse and fluctuating nature of male behaviour both within individual men, between communities of men, and across men in different cultural settings. Research must also be sensitive to how ideas of male gender interact with other identity markers such as sexuality, race, and disabilities (Ridge, 2019; Struszczyk, Galdas & Tiffin, 2019; Seidler, Rice, Ogrodniczuk, Oliffe & Dhillon, 2018).

Findings from this thesis support scholarly recommendations for developing updated quantitative measures of masculinity (Thompson & Bennett, 2015). The characteristics that have dominated quantitative explorations of masculinity include avoiding the feminine, concealing emotions, status pursuit, dominance, violence, primacy of work, self-reliance, power over women, and the rejection of homosexuals (Brannon & Juni, 1984; Levant & Fischer, 1998; Mahalik et al., 2003; Oransky & Fisher, 2009; Thompson & Pleck, 1986). While gender theorists have suggested that norms of masculinity are anchored in the drive to claim power and deny feminine and/or homosexual associations these ideas were not dominant in our data. Masculine characteristics that were more prevalent in our findings related to emotional suppression and self-reliance; feelings of failure, shame, loss of social status, and social value; interpersonal isolation and loneliness. Men's distress at not living up to certain masculine ideals may be implicitly driven by a fear of not establishing power over others and/or being perceived as feminine/homosexual i.e., the belief that pain cannot be expressed is potentially rooted in an underlying assumption that to do so would be 'gay' or 'womanly.' However, it is important to note that most participants did not articulate their compliance to masculine norms as driven by these concerns. This suggests a potential disconnect between the scholarly framing of masculine norms and how some lay people

understand their conformity to masculine ideals. This is not to say homophobia and misogyny do not still exist with devastating consequences, nor that fears of being perceived as feminine or homosexual are not potentially prevalent among some communities of men, it is simply to acknowledge that societal shifts may have influenced some aspects of masculine norm formation, and this was potentially reflected in our data. Future research to understand how masculinity is constructed in different cultural contexts and the norms that may be most relevant to suicide risk is critical. A key question prioritised in the Delphi study (Study 4, Chapter 6) was understanding how men who are suicidal develop and form their ideas of masculinity. In particular, understanding how gendered ideas relating to psychological pain, emotions, male selfhood, and interpersonal connections impact men who are suicidal could be significant.

Similarly, while individual men embody forms of masculinity, masculinity is judged, supported, reinforced, challenged, sustained, and enforced by others (Ridge, 2019). Findings from this thesis also suggest the importance of exploring how masculine norms impact other people's perceptions and expectations of male behaviour. For example, in Studies 1 and 3, data suggest that men who are suicidal had negative experiences accessing help, where their distress was misread as not being severe enough to indicate an imminent crisis or hostile attitudes to men were expressed by professionals. A future priority question from the Delphi (Study 4) is to investigate how male distress is understood and responded to by others. It may also be necessary for future investigations of male norms and male suicide to explore the role and influence of women in the construction of masculinity. As Connell & Messerschmidt (2005) assert, women can be central conduits for supporting and/or challenging masculine norms in their relationships to men as mothers, partners, sisters, friends, and colleagues.

7.3.2 Reconceiving Suicide Prevention Approaches and Actors

Recommendations from this thesis support other scholarly work in questioning where the boundaries of suicide prevention and intervention should lie. A recent review of evidence on premature deaths from mental health has highlighted the importance of taking a multilevel approach and addressing structural inequalities, cultural issues, as well as individual risk factors (O'Connor et al., 2023). The question of appropriate boundaries is perhaps best expressed via Rudd's (2006) 'Fluid Vulnerability Theory' (FVT), which distinguishes between a person's active suicidal mode and their baseline risk. Should suicide prevention

only focus on deactivating a person's active suicidal mode with interventions such as safety planning and/or Cognitive Behavioural Therapy (CBT) potentially most valuable? Or should it also take on the more extensive, broader work of also diminishing baseline risk factors? This would see the boundaries of suicide prevention merge with other domains, such as homelessness prevention, addiction support, and disability welfare, in tackling social ills that may drive psychological pain in many ways, some of which may lead to suicide. This may be necessary given that a course of CBT may help a man develop better tools to manage thoughts of suicide, yet, if the conditions of his life continue to expose him to distress - such as chronic unemployment, homelessness, parental alienation, and/or homophobia - his psychological pain may remain high. This is not to say that the CBT is not a necessary intervention but that it may not be sufficient to reduce lifetime suicide risk. While a suicide may be prevented at that moment, without further support, a man may remain in a high state of psychological pain, and struggling to access a life that can be subjectively well-lived. This calls into question the goal of suicide prevention. Is it only to prevent death at a specific moment, irrespective of the painful conditions of existence a person may continue to live in? Or should it, as Button (2016) described, also be concerned with securing "the conditions of human dignity for all persons" (p. 270)? In this conceptualisation, suicide prevention would be focused not just on preventing deaths but on tackling systemic drivers of psychological pain and helping people who are suicidal not just to stay alive, but to access meaningful and dignified existences (Bryan, 2022). Findings from this thesis suggest we may need to think more holistically and long-term about suicide prevention and recovery. For many men who took part in this research, suicidal behaviours were the consequence of tremendous pain. That pain often accrued over many years from multiple interacting sources. Each man who is suicidal often embodies a complex web of lived experiences, personality traits, potential psychiatric diagnoses, cultural beliefs, relationship challenges, schemas of self, tools to regulate emotions, economic means, education levels, acute stressors and more, all of which can converge on his decision to end his life (O'Connor et al, 2023). This complexity is true of many health outcomes. Suicide is no different. Given this complexity, singular, time-limited interventions may have limited efficacy in substantially easing suicidal pain.

Bryan (2022) suggested that identifying who is most at risk of suicide may be as fruitless as predicting who is most at risk of a traffic fatality. In order to reduce traffic fatalities, work has focused on changing the environment within which accidents happen through policies such as seatbelt laws and speeding restrictions, rather than trying to identify individuals most at risk.

Bryan argued that suicide prevention may need to adopt a similar approach. Findings from this thesis potentially support this position. We may have to accept that developing robust and reliable predictors of suicide may be unworkable given the complexity of the phenomena, its low base rate, and its temporal nature. The spectrum of stories conveyed in the qualitative meta-synthesis (Study 1) reveals some of the diversity of the profile of factors that can lead to male suicidal behaviour. In a study from Brazil one man was described as "aggressive and macho", another as the "the community's moral support" both men went on to die by suicide (p. 1988, Meneghel et al., 2012). Suicidal thoughts were reported as frightening to some men, and freeing to others (Biong & Ravndal et al., 2009). Warning signs of advanced suicidal despair were described as presenting in some men as an apparent escalation in distress, but in others as the sudden emergence of calmness and serenity (Pavulans et al., 2012). The psychological pain referenced at the point of suicidal action was described by some men as "a boiling inside", by others as "a dark emptiness" (p.250, Biong & Ravndal et al., 2007). Some men described their suicide attempt as frightening and indicative of a distressing loss of control (Elliott-Groves, 2018; Mackenzie at al., 2018; Pavulans et al., 2012), other men reported solace and calm during their attempt and bringing an end to their pain (Crocker et al., 2006; Rivlin at al., 2013; Tryggvadottir et al., 2019). Suicides were described as both "unforeseen" with no apparent previous warning of distress, or "rationalised" when men were understood to have had a long history of profound struggles (p. 1392, Oliffe et al., 2018). Some men described their suicide attempt as a wake-up call and suggested that they were relieved it didn't work, others reported being upset to still be alive, and stated that their attempt only strengthened their resolve to try again (Rivlin et al., 2013; Vatne & Naden, 2012; Vatne & Naden, 2016). Knizek and Hjelmeland (2018) found in their study that 75% of participants understood interpersonal stressors as a key trigger for their attempt, however, these stressors appeared to provoke very different primary emotions and related to different types of challenges. Therefore, even when a risk factor such as 'relationship stressors' is identified differences within this category may often be bigger than similarities (Knizek & Hjelmeland, 2018). Some men disclosed suicidal thoughts and plans but on the eve of their death gave reassurances to significant others that they did not intend to go through with their suicide plans (Sweeney et al., 2015). The seemingly fluctuating nature of suicidality means some men might not be rated as high risk during a clinical assessment but go on to die soon after (Bryan & Rudd, 2016; Pisani et al., 2016; Rudd, 2006). Further detailed research may bring this diversity into categorical nomenclatures that are amenable to tailored risk profiles,

assessment, and interventions. Or suicide may remain a diverse behaviour that makes targeted risk prediction a dynamic, and elusive target.

Findings from this thesis also suggest the importance of expanding our understanding of intervention actors. The emergence of suicidology as a scientific discipline led to suicide being primarily understood as a medical issue, which has constrained how we understand and respond to suicidal pain (Fitzpatrick, Hooker & Kerridge, 2015). People who are suicidal can be perceived as sites of illness, and prevention and intervention the dominions of those in clinical, medical, and mental health professions. Our findings support the view that suicide prevention may require a broader lens with significant others and community interventions potentially having significant value (Bryan, 2022; O'Connor et al., 2023). If the hypothesis that regulating emotions, self, and connections with others can help men who are suicidal regulate psychological pain and suicide risk, has utility, this could open up multiple ways in which effective interventions may occur. Any interaction that facilitates men to build connection and regulation in these domains could potentially contribute to a man's recovery. Evidence from this thesis suggests that interventions such as peer support and volunteering helped support some men's recovery as well as many men rejecting the medicalisation of their distress.

7.4 Limitations

This thesis sought to enhance our understanding of the psychological dimensions underpinning male suicide. While progress was made against this aim, there are significant limits to the validity, applicability, and value of findings. Limitations relating to each empirical study are documented in their respective chapters. This section recaps some of the primary issues that need to considered when evaluating the findings described in this thesis.

7.4.1 Methodological Limitations

Each empirical study was limited by the fact that men who have died by suicide cannot be directly studied. These men may be qualitatively different to men with thoughts of suicide, men who have attempted, and/or how people bereaved by male suicide remember them. This limitation applies to all suicide research and will always restrict the validity of findings.

Samples recruited for this thesis were instead drawn from men who were suicidal and those bereaved by male suicide. Alongside being different from men who have died, their testimonies may have additional limitations. In terms of insights derived from men who were suicidal, unless they were actively suicidal at the time of participating in the research, their testimonies may be subject to recall bias (De Leo et al., 2006). Similarly, people bereaved by male suicide may filter their own accounts and understandings of their loved ones through their own perspectives and potential biases (Owens, 2008; Sweeney et al., 2015). All studies were limited by what participants were willing to disclose and/or what they understood of their behaviours, motivations, and intentions (Chung et al, 2015). Important factors may have been omitted because participants felt uncomfortable expressing them or were in denial about them.

Study 1 and Study 3 used a qualitative methodology. White (2017) cautioned that qualitative research must not be understood as a process by which research teams can discover permanent and reliable truths within participants' narratives in "objective and transparent ways" (p. 475). This is a dangerous fallacy and can create the false impression that there is some objective reality to qualitative findings. Instead, qualitative work concerns a particular research team's interpretation of a potential reality within a data set. This interpretation is rooted in evidence within the data, but a different research team could make different interpretations, and qualitative findings must always be viewed through this caveat. While qualitative research does not provide evidence that can be generalized to all populations, our findings offer the potential for transferability to other contexts. Findings from Study 3 may be further limited by the phrasing of the question. The word 'barriers' may have been interpreted differently by different men and may have reduced the consistency of responses."

Study 2 used a cross-sectional quantitative design. The "quantification of psychological phenomena" has been criticised for simplifying human behaviour to produce scientific credibility via statistically generated findings that are ultimately limited in their utility in advancing our understanding of behaviour (p. 68, Coolican, 2009). This criticism is particularly relevant to one of the most complex behaviours in the human repertoire - suicide. Quantitative data only has a single property: "value or magnitude" (p.24, Hand, 2008). Concerning a behaviour as complicated as suicide, the singular property of quant-generated data can have limited utility in meaningfully enhancing our understanding of why people are at risk of harming themselves. Additionally, the premise of Study 2 was to translate the

qualitative findings from Study 1 into measurable psychometric tools to further explore our findings. Turning abstract or theoretical concepts into specific, measurable variables that can be studied and analyzed is always an imprecise endeavour. Findings from Study 2 are therefore compromised by the inherent challenges of making abstract concepts concrete and measurable. Findings from Study 2 must be considered in the context of these limitations

Finally, Study 4 used a modified Delphi methodology to build expert consensus but is limited by the fact that it could not incorporate the views of every male suicide expert. As noted in the study, our expert panel lacked representation from minority groups. As such, important research questions were potentially omitted. While each study design had specific limitations, using a mixed-methods approach in this thesis has helped balance some of these restrictions. A mixed-methods approach allows researchers to build on the findings gleaned by one methodology via another, to triangulate validity (Morgan, 2007). For example, the cross-sectional study (Study 2) used a quantitative approach to test findings from the qualitative meta-synthesis (Study 1).

7.4.2 Research Team Limitations

A man who is suicidal cannot be understood in isolation from the biological, environmental, cultural, political, and structural conditions of his life nor the evolutionary context that has borne and sustained human existence (Button, 2016; Hjemland, 2013; Sloan Wilson, 2019). Building a better understanding of suicide requires work from multiple disciplines that can offer answers to different questions that may all be relevant (Chandler, 2020). A sociologist may provide a structural analysis for increased male suicide during times of political upheaval; an endocrinologist could look at the role of testosterone; an evolutionary psychologist could explore how the emergence of human selfhoods may have elevated risk. It was beyond the remit of this thesis to explore all the disciplinary dimensions relevant to male suicide, and any study of suicide confined to one scientific discipline, will only be able to reveal limited insights. This work took a psychological perspective and generated findings based on this viewpoint. A central claim of this thesis is the potential role of cultural norms of masculinity in male suicide. However, the role of male biological sex and evolutionary pressures on male behaviour cannot be untangled or dismissed from the data of this thesis. Emotional suppression may increase male suicide risk, but how much of this is because of cultural pressures for men to adopt this behaviour versus biological impulses to do so is

unknowable. This limits how much the role of culture can be reliably claimed as central and findings must be considered in the context of biology and evolution's potential and unknown influence.

All the findings from this thesis are based on the interpretations of the researcher and collaborators. As mentioned, I have a closeness to the material through lived experience which will have shaped my interpretation of data, and the privileging of certain ideas and experiences. To address this, each study followed a systematic methodology and findings have also been triangulated via multiple collaborators and my supervisors. Nonetheless, different research terms, with different cultural sensibilities, lived experiences, and psychological sensitivities may have made different interpretations, asked different research questions, and used different research designs. Similarly, the researcher, supervisory team, collaborators, and participants were mainly white, cis people from upper-income contexts. This homogeneity will also limit the generalisability of findings. This is a challenge reflected in suicidology at large, where findings are primarily western (O'Connor & Nock, 2014). In particular, the descriptions of masculinity in this thesis were rooted in a western perspective. Further cultural and demographic-specific research will no doubt reveal significant nuance and challenges to the ideas proposed here.

7.4.3 Limitations of Applicability and Utility of Findings

In the introduction, some of the key challenges facing suicidology were reviewed, including that, after 50 years of research, our ability to predict who is most at risk of suicide is nominal (Franklin et al., 2017). This criticism also pertains to findings from this thesis, which potentially lack specificity and utility in understanding male suicide specifically. The core idea that dysregulation in emotions, self, and connections with others could elevate suicide risk is a hypothesis that could potentially apply to other kinds of dysregulated behaviours, such as substance abuse, violence, social withdrawal, and gambling. Instead of trying to predict suicide precisely, there may be more value in thinking of dysregulated psychological pain as a catalyst for various dysregulated behaviours. Focusing on tackling and resolving people's exposure to excessive psychological pain and enhancing their tools to regulate pain may be more effective than trying - within an amorphous and dynamically shifting ocean of pain - to border off the waters that relate to suicide specifically. In such a context, the findings from this thesis would have more utility.

Conclusion

In sum, this thesis contributes four empirical studies to advance our understanding of the relationship between male gender, male psychology, and male suicide. From these studies, eight recommendations for theory development and 60 recommendations for future research, prevention, and intervention are made. The scale of male suicide means investigations into its causes and ways to reduce its prevalence are urgent. This thesis began by looking at male suicide from a macro level - reviewing 20 years of qualitative literature to generate hypotheses about the psychological pathways underpinning male suicide. Findings suggested the importance of understanding the harms cultural norms of masculinity may do to men by facilitating denial, disconnection, and dysregulation in men's relationship with their emotions, self, and others. Study 2 took these findings and tested them in a cross-sectional design. Findings suggested that dysregulation in the domains of emotions, self, and connections with others increased as suicidal behaviours increased from none to thoughts of suicide to an attempt. Study 3 explored the barriers men who are suicidal experience around accessing professional support, with norms of masculinity appearing to limit men's help-seeking behaviours. Despite consistently high male suicide rates, there has been a lack of research into male vulnerability to suicide. Data from this thesis demonstrate how much work still needs to be done to develop a robust understanding of male suicide. Study 4 developed an agenda of research priorities to help target resources effectively.

This thesis has used a mixed-methods approach to generate hypotheses about the relationship between male gender, male psychology, and male suicide. Many of the ideas expressed here are in an embryonic form. As such, they will require robust future interrogation before we can claim to have established valuable insight into male suicide. Knowledge development is "iterative in nature", and hopefully, findings from this thesis can catalyse future research that scrutinises, challenges, tests, and expands all the ideas proposed here (p. 902, Finfgeld, 2003). This future work will no doubt reveal that some findings are wrong, misaligned or require additional nuance and caveats. I hope the findings from this thesis can provide a valuable roadmap to help direct this future work. This thesis primarily sought to fill the gap in research with regards our understanding of the relationship between male gender, male psychology, and male suicide. Findings suggest the importance of exploring this interaction.

Tackling the male suicide crisis may require adopting a gender, and culturally sensitive, perspective, which acknowledges the influence of masculine norms on male psychological pain, and how this distress is perceived and responded to (Seidler et al., 2019). Enhancing our understanding of specific masculine norms and their potential detrimental effects on men may be essential for developing effective strategies in male suicide prevention and intervention.

Appendices

Appendix 3.1 Search Strategy (Study 1, Chapter 3)

Research Question: What are the understandings and experiences of men who are suicidal, and those bereaved by male suicide, of the factors that put men at risk of suicide, and the factors that can help protect them?

Restrictions: English Language / Published between 2000 and 2020

1. EBSCO: CINAHL

Search 1:
((MH "Men") OR (MH "Battered Men") OR (MH "Gay Men") OR (MH "Men Who Have Sex With Men") OR (MH "Single Men") OR (MH "Male") OR (MH "Masculinity")) OR (TI (men or males or man or male) OR AB (men or males or man or male) OR TI (masculinity or masculine or manhood) OR AB (masculinity or masculine or manhood))

Search 2:
((MH "Suicide+") OR (MH "Suicide, Attempted") OR (MH "Suicidal Ideation")) OR (TI suic* OR AB suic*)

Search 3:
((MH "Qualitative Research+") OR (MH "Grounded Theory") OR (MH "Hermeneutics") OR (MH "Interview") OR (MH "Interview, Psychological") OR (MH "Interviews as Topic") OR (MH "Focus Groups") OR (MH "Case Reports") OR (MH "Anthropology, Cultural") OR (MH "Observation") OR (MH "Personal Narrative") OR (MH "Personal Narratives as Topic")) OR (TI qual* OR AB qual* OR TI phenomenol* OR AB phenomenol* OR TI reflexivity* OR AB reflexivity* OR TI interview* OR AB interview* OR TI focus* OR AB focus* OR TI ethnograph* OR AB ethnograph* OR TI “case stud*” OR AB “case stud*” OR TI observational* OR AB observational* OR TI thematic* OR AB thematic* OR TI narrative* OR AB narrative* OR TI discourse* OR AB discourse* OR TI “grounded theory” OR AB “grounded theory” OR TI “psychological autopsy” OR AB “psychological autopsy” OR TI “mixed methods” OR AB “mixed methods”)

Search 4: Search 1 AND Search 2 AND Search 3
Search 5: English language
Search 6: Published between 2000 - 2020

2. EBSCO: Medline

Search 1:
((MH "Male") OR (MH "Men+") OR (MH "Men's Health") OR (MH "Masculinity")) OR (TI (men or males or man or male) OR AB (men or males or man or male) OR TI (masculinity or masculine or manhood) OR AB (masculinity or masculine or manhood))

Search 2:
((MH "Suicide") OR (MH "Suicide, Attempted") OR (MH "Suicidal Ideation")) OR (AB suic* OR TI suic*)

Search 3:
((MH "Qualitative Research+") OR (MH "Grounded Theory") OR (MH "Hermeneutics") OR (MH "Interview") OR (MH "Interview, Psychological") OR (MH "Interviews as Topic") OR (MH "Focus Groups") OR (MH "Case Reports") OR (MH "Anthropology, Cultural") OR (MH "Observation") OR (MH "Personal Narrative") OR (MH "Personal Narratives as Topic")) OR (TI qual* OR AB qual* OR TI phenomenol* OR AB phenomenol* OR TI reflexivity* OR AB reflexivity* OR TI interview* OR AB interview* OR TI focus* OR AB focus* OR TI ethnograph* OR AB ethnograph* OR TI “case stud*” OR AB “case stud*” OR TI observational* OR AB observational* OR TI thematic* OR AB thematic* OR TI narrative* OR AB narrative* OR TI discourse* OR AB discourse* OR TI “grounded theory” OR AB “grounded theory” OR TI “psychological autopsy” OR AB “psychological autopsy” OR TI “mixed methods” OR AB “mixed methods)

Search 4: Search 1 AND Search 2 AND Search 3
Search 5: English language
Search 6: Published between 2000 - 2020

3. EBSCO: PsycINFO

Search 1:
(DE "Psychology of Men" OR DE "Human Males" OR DE "Masculinity") OR (TI (men or males or man or male) OR AB (men or males or man or male) OR TI (masculinity or masculine or manhood) OR AB (masculinity or masculine or manhood))

Search 2:
(DE "Suicide Prevention" OR DE "Suicidology" OR DE "Psychological Autopsy" OR DE "Suicidality" OR DE "Suicide" OR DE "Attempted Suicide" OR DE "Risk Factors" OR DE "Suicidal Ideation") OR (TI suic* OR AB suic*)

Search 3:
(DE "Qualitative Measures" OR DE "Qualitative Methods" OR DE "Mixed Methods Research" OR DE "Interviews" OR DE "Semi-Structured Interview" OR DE "Interviewing" OR DE "Interviewers" OR DE "Interview Schedules" OR DE "Focus Group" OR DE "Focus Group Interview" OR DE "Ethnography" OR DE "Observation Methods" OR DE "Participant Observation" DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Thematic Analysis" DE "Narrative Analysis" OR DE "Psychological Autopsy" OR DE "Content Analysis" OR DE "Discourse Analysis" OR DE "Narrative Analysis" OR DE "Sentiment Analysis" OR MM "Social Network Analysis") OR (TI qual* OR AB qual* OR TI phenomenol* OR AB phenomenol* OR TI reflexivity* OR AB reflexivity* OR TI interview* OR AB interview* OR TI focus* OR AB focus* OR TI ethnograph* OR AB ethnograph* OR TI “case stud*” OR AB “case stud*” OR TI observational* OR AB observational* OR TI thematic* OR AB thematic* OR TI narrative* OR AB narrative* OR TI discourse* OR AB discourse* OR TI “grounded theory” OR AB “grounded theory” OR TI “psychological autopsy” OR AB “psychological autopsy” OR TI “mixed methods” OR AB “mixed methods”)

Search 4: Search 1 AND Search 2 AND Search 3
Search 5: English language
Search 6: Published between 2000 - 2020

4. EBSCO: PsycARTICLES

Search 1:
(DE "Human Males" OR DE "Brothers" OR DE "Fathers" OR DE "Husbands" OR DE "Male Criminal Offenders" OR DE "Sons" OR DE "Widowers" OR DE "Male Attitudes") OR (TI (men or males or man or male) OR AB (men or males or man or male) OR TI (masculinity or masculine or manhood) OR AB (masculinity or masculine or manhood))

Search 2:
(DE "Psychological Autopsy" OR DE "Attempted Suicide" OR DE "Suicidal Ideation" OR DE "Suicidality" OR DE "Suicide" OR DE "Suicide Prevention" OR DE "Suicidology") OR (TI suic* OR AB suic*)

Search 3:
(DE "Focus Group Interview" OR DE "Qualitative Methods" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis" OR DE "Interviews" OR DE "Mixed Methods Research" OR DE "Observation Methods" OR DE "Qualitative Measures" OR DE "Discourse Analysis" OR DE "Narrative Analysis") OR (TI qual* OR AB qual* OR TI phenomenol* OR AB phenomenol* OR TI reflexivity* OR AB reflexivity* OR TI interview* OR AB interview* OR TI focus* OR AB focus* OR TI ethnograph* OR AB ethnograph* OR TI “case stud*” OR AB “case stud*” OR TI observational* OR AB observational* OR TI thematic* OR AB thematic* OR TI narrative* OR AB narrative* OR TI discourse* OR AB discourse* OR TI “grounded theory” OR AB “grounded theory” OR TI “psychological autopsy” OR AB “psychological autopsy” OR TI “mixed methods” OR AB “mixed methods”)

Search 4: Search 1 AND Search 2 AND Search 3
Search 5: English language
Search 6: Published between 2000 - 2020

5. EBSCO: Psychology and Behavioral Sciences Collection

Search 1:
(DE "MEN" OR DE "MALES" OR DE "MASCULINITY") OR (TI (men or males or man or male) OR AB (men or males or man or male) OR TI (masculinity or masculine or manhood) AND AB (masculinity or masculine or manhood))

Search 2:
(DE "SUICIDAL behavior" OR DE "SUICIDAL behavior in Native Americans" OR DE "SUICIDAL behavior in college students" OR DE "SUICIDAL behavior in young adults" OR DE "SUICIDAL behavior in youth" OR DE "SUICIDE" OR DE "TEENAGE suicide" OR DE "SELF-poisoning" OR DE "SUICIDE notes" OR DE "HANGING (Death)" OR DE "SUICIDE prevention" OR DE "SUICIDAL ideation" OR DE "SELF-destructive behavior" OR DE "SUICIDE" OR DE "COPYCAT suicide" OR DE "SUICIDAL behavior") OR (TI suic* OR AB suic*)

Search 3:
(DE "QUALITATIVE research" OR DE "MIXED methods research" OR DE "SEMI-structured interviews" OR DE "FOCUS groups" OR DE "INTERVIEWING" OR DE "ETHNOGRAPHIC analysis" DE "CASE studies" OR DE "PARTICIPANT observation" OR DE "OBSERVATION (Psychology)" DE "THEMATIC analysis" OR DE "NARRATIVE discourse analysis" OR DE "DISCOURSE analysis" OR DE "QUALITATIVE research"DE "CONTENT analysis" OR DE "GROUNDED theory") OR (TI qual* OR AB qual* OR TI phenomenol* OR AB phenomenol* OR TI reflexivity* OR AB reflexivity* OR TI interview* OR AB interview* OR TI focus* OR AB focus* OR TI ethnograph* OR AB ethnograph* OR TI “case stud*” OR AB “case stud*” OR TI observational* OR AB observational* OR TI thematic* OR AB thematic* OR TI narrative* OR AB narrative* OR TI discourse* OR AB discourse* OR TI “grounded theory” OR AB “grounded theory” OR TI “psychological autopsy” OR AB “psychological autopsy” OR TI “mixed methods” OR AB “mixed methods”)

Search 4: Search 1 AND Search 2 AND Search 3
Search 5: English language
Search 6: Published between 2000 - 2020

6. EBSCO: SocINDEX with Full Text

Search 1:
(DE "MALES" OR DE "MEN" OR DE "MASCULINITY") OR (TI (men or males or man or male) OR AB (men or males or man or male) OR TI (masculinity or masculine or manhood) AND AB (masculinity or masculine or manhood))

Search 2:
(DE "SUICIDAL behavior" OR DE "SUICIDAL behavior in college students" OR DE "SUICIDAL behavior in young adults" OR DE "SUICIDAL behavior in youth" OR DE "SUICIDE" OR DE "TEENAGE suicide" OR DE "SUICIDAL ideation" OR DE "SUICIDE" OR DE "SUICIDE prevention" OR DE "SUICIDE" OR DE "SUICIDE -- Cross-cultural studies" OR DE "RISK factors in suicidal behavior" OR DE "SUICIDE risk factors") OR (TI suic* OR AB suic*)

Search 3:
(DE "QUALITATIVE research" OR DE "FOCUS groups" OR DE "PARTICIPANT observation" OR DE "INTERVIEWING" OR DE "DISCOURSE analysis" OR DE "CONTENT analysis") OR (TI qual* OR AB qual* OR TI phenomenol* OR AB phenomenol* OR TI reflexivity* OR AB reflexivity* OR TI interview* OR AB interview* OR TI focus* OR AB focus* OR TI ethnograph* OR AB ethnograph* OR TI “case stud*” OR AB “case stud*” OR TI observational* OR AB observational* OR TI thematic* OR AB thematic* OR TI narrative* OR AB narrative* OR TI discourse* OR AB discourse* OR TI “grounded theory” OR AB “grounded theory” OR TI “psychological autopsy” OR AB “psychological autopsy” OR TI “mixed methods” OR AB “mixed methods”)

Search 4: Search 1 AND Search 2 AND Search 3
Search 5: English language
Search 6: Published between 2000 - 2020

7. Web of Science: Core Collections

Topics:

- Men OR males OR man OR male OR masculinity OR masculine OR manhood
- AND suic*
- AND qual* OR phenomenol* OR reflexivity* OR interview* OR focus* OR ethnograph* OR case stud* OR observational* OR thematic* narrative* OR discourse* OR grounded theory

Appendix 3.2 Quality Appraisal Tool, Example (Study 1, Chapter 3)

Paper Title.	Reasons for attempting suicide: An exploratory study in Ghana
Author/s.	Akotia, C. S., Knizek, B. L., Hjelmeland, H., Kinyanda, E., & Osafo, J.
Year.	2019
Location.	Ghana

SCREENING QUESTIONS.

1. Is a qualitative methodology appropriate?

For example:

- Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?
- Or could a quantitative approach better have addressed the research question?

Appropriate / Inappropriate / Not sure: Appropriate.

Comment: The research seeks to interpret and illuminate the subjective experiences of research participants with lived experience relating to the research question.

2. Is the study clear in what it seeks to do?

For example:

- Is the purpose of the study discussed – aims/objectives/ research question(s)?
- Are the values/assumptions/theory underpinning the purpose of the study discussed?

Clear / Unclear /Mixed: Clear.

Comment: This paper part of a bigger study looking at cultural contexts of suicide in Norway, Uganda and Ghana, this paper focuses on understanding: what lead people in Ghana to a suicide attempt?

DETAILED QUESTIONS.

3. How defensible/rigorous is the research design/ methodology?

For example:

- Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used?)

Defensible / Not defensible / Not sure: Defensible

Comment: Clear rationale for using the interview method, the sampling and analysis methods.

4. How well was the data collection carried out?

For example:

- Are the data collection methods clearly described?
- Were the data collected appropriate to address the research question?

Appropriate/ Inappropriate / Not sure/ Inadequately reported: Appropriate

Comment: Clearly described and appropriate to the research question.

5. Is the context clearly defined?

For example:

- Are the characteristics of the participants and settings clearly defined?
- Was context bias considered (that is, did the authors consider the influence of the setting where the study took place)?

Clear / Unclear / Not Sure: Clear

Comment: Characteristics of the participants defined, clear settings for the interviews described - private rooms in emergency hospitals.

6. Were the methods reliable?

For example:

- Were data collected by more than one method?
- Were other studies considered with discussion about similar/ different results?

Reliable / Unreliable / Not sure: Reliable

Comment: Data collected via one method – narrative interviews

7. Is the data analysis sufficiently rigorous?

For example:

- Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results?
- How systematic is the analysis, is the procedure reliable/dependable?
- Is it clear how the themes and concepts were derived from the data?

Rigorous / Not rigorous / Not sure/not reported: Rigorous

Comment: Procedure explicit, systematic and clear how themes and concepts were derived.

8. Are the data 'rich'?

For example:

- How well are the contexts of the data described?
- Has the diversity of perspective and content been explored?
- Has the detail of the data that were collected been demonstrated?
- Are responses compared and contrasted across groups/sites?

Rich / Poor / Not sure/ Not reported: Rich

Comment: Rich data with a clear seperation between gendered findings in responses which are compared and contrasted. Good linkage with previous research.

9. Is the analysis reliable?

For example:

- Did more than one researcher theme and code transcripts/ data?
- If so, how were differences resolved?
- Were negative/discrepant results addressed or ignored?
- Is it clear how the themes and concepts were derived from the data?

Reliable / Unreliable / Not sure / Not Reported: Reliable

Comment: A team of researchers worked on the analysis.

10. Are the findings convincing?

For example:

- Are the findings clearly presented?
- Are the findings internally coherent (that is, are the results credible in relation to the study question)?
- Are extracts from the original data included (for example, direct quotes from participants)?
- Are the data appropriately referenced so that the sources of the extracts can be identified?
- Is the reporting clear and coherent?

Convincing / Not Convincing / Not Sure: Convincing

Comment: Findings clearly presented and coherent, data extracts included.

11. Are the conclusions adequate?

For example:

- How clear are the links between data, interpretation and conclusions?
- Are the conclusions plausible and coherent?
- Have alternative explanations been explored and discounted?
- Are the implications of the research clearly defined?
- Is there adequate discussion of any limitations encountered?

Adequate / Inadequate / Not sure: Adequate

Comment: Clear - reasons for suicide in this context appear to be largely social and cultural

12. How clear and coherent is the reporting of ethics?

For example:

- Have ethical issues been taken into consideration?
- Are they adequately discussed e.g. do they address consent and anonymity?
- Have the consequences of the research been considered i.e. raising expectations, changing behaviour? Was the study approved by an ethics committee?

Appropriate / Inappropriate / Not sure/not reported: Appropriate

Comment: Very clear ethics process documented and the process of working with translators and translations.

13. Is the role of the researcher clearly described?

For example:

- Has the relationship between the researcher and the participants been adequately described?
- Is how the research was explained and presented to the participants described?

Clearly described / Not clear / Not sure/not reported: Clear

Comment: Research clearly explained to participants and the relationship between researcher and participant adequately described.

14. How valuable or useful is the research?

For example:

- Does the research add to knowledge, or increase the confidence with which existing knowledge is regarded?
- Is there discussion of how findings relate to wider theory; consideration of rival explanations?
- What are the implications for policy and practice – how is it 'fit for purpose'?

Valuable / Not clear / Not Valuable: Valuable **Comment:** Strong policy and service delivery recommendations

Quality Assessment.

Population	**Methods**	**Analysis**	**Relevance to systematic Review**
Well Reported	Well Reported	Well Reported	Relevant.
Overall Assessment	++ / + / - ++		

Appendix 3.3 Data Extraction Tool, Example (Study 1, Chapter 3)

Paper Title.	Reasons for attempting suicide: An exploratory study in Ghana
Author/s.	Akotia, C. S., Knizek, B. L., Hjelmeland, H., Kinyanda, E., & Osafo, J.
Year.	2019
Location.	Ghana
Does the evidence fit within the scope of the review? Yes	
Evaluative Summary. This is a strong paper with no obvious weakness, that narrates the suicidal experience in the context of Ghana and the cultural and social factors that put individuals at risk of unmanageable despair.	

---

1. STUDY AIMS AND PURPOSE
1.1 Is there a clear statement of aims for the research? (Clear/ Unclear/ Mixed Comments) Clear.
1.2 What are the aims of the research? This paper part of a bigger study looking at cultural contexts of suicide in Norway, Uganda and Ghana, this paper focuses on understanding: what lead people in Ghana to a suicide attempt?

2 SAMPLE
2.1 What is the population being studied? People who have attempted suicide.
2.2 What is the inclusion/exclusion criteria? Inclusion: all participants over 18 who had attempted to kill themselves with the intention to die and brought into the emergency unit of the hospital for medical treatment.
2.3 How was the sample selected? Did any factors influence this? Emergency room nurses were briefed on the study and invited to contact the author when there was a suitable admission.
2.4 What are the number of participants? 30
2.5 What are their demographic characteristics? (e.g., Gender/ age/ ethnicity/ sexuality/ SES) 12 men and 18 women; age 18-46
2.6 Is the sample appropriate to meet the study aims? Yes
2.7 Where did the research take place? In a private office in the emergency departments of hospitals.
2.8 What is the rationale and appropriateness for this choice? The privacy and safety of interviewees and participants.
2.9 When did the data collection take place? Consent was secured within a week of referral.

3 DATA COLLECTION
3.1 What were the methods? Narrative interviews
3.2 What is the role of the researcher within the setting? Are there any conflicts? Not disclosed
3.3 Is the fieldwork adequately described? Yes.
3.4 Are the researcher's /researchers' own position, assumptions and possible biases outlined? Indicate how they could affect the study in terms of analysis and interpretation of the data. Not Clear
3.5 How was the data analysed? IPA

3.6 How adequate is the description of the data analysis? Is adequate evidence provided to support the analysis (e.g. use of original data, iterative analysis, efforts to establish validity and reliability)?
Adequate

4. ETHICAL STANDARDS

4.1 Was ethical approval obtained? Yes

4.2 Was informed consent obtained? Yes

4.3 Has confidentiality been maintained? Yes

4.4 Are ethical issues addressed? Yes

5. FINDINGS

5.1 What are the key themes?

1. Lack of Support
   - Not given the family and social support that culture has taught them to expect
2. Abandonment
   - A theme amongst the women - not relevant
3. Shame
   - Only cited by men - being in situations that were damaging to social standing, or image: financial difficulties or marital infidelity - loss of dignity - "death could provide an escape from the impending shame." p. 239
   - In Ghanian society successful masculinity is measure by the ability to meet the economic needs of one's family. p. 239
   - A man who can't provide for his family faces social stigma / Money is a means of achieving social standing.
   - Similarly infidelity is a source of shame - that you can't satisfy and keep your wife: "I was feeling very sad, very sad that this has happened to me. Me! ...for someone to be sleeping with my wife? I was so down and I thought the best is to end it all. In this case, I will not see or hear anything again ...the humiliation ... it's painful, you know. (Man, 28)" p.240
   - The thought of having lost face is unbearable to the extent that this informant decided to try to kill himself.
4. Existential Struggles
   - Only men cited these reasons. Loss of faith in themselves "descrives a general feeling of inadequacy or sense of failure in life as a central reason for the suicide attempt" p. 240
   - "I have messed up my life" p.241
   - Struggles with self-worth / failed ambition / disappointed in self / misused their life / self-evaluation very negative
   - In Ghana, where social expectations pressure men to provide for their families, internalizing such views of the self may amplify feelings of failure, inadequacy, and distress. p. 241
3. Supernatural reasons
   - "It was like a spirit entered me to do it" p. 241
   - Considering the Ghanaian social context, where men are expected to be brave and face challenges in life (Adinkrah, 2010), denying responsibility and blaming external forces for their action perhaps saves them from ridicule. p. 242

5.2 Are the findings substantiated by the data and has consideration been given to any limitations of the methods or data that may have affected the results?
Yes.

5.3 What are the conclusions?

- Support for attempted suiciders needs to be really robust given their vulnerability to go on and complete.
- Cultural and social factors need to be considered in a suicidal crisis

6. POLICY AND PRACTISE

6.1 To what extent are the study findings generalisable and applicable to practise? Sample is from Ghana and too small to be generalisable and applied to practise.

6.2 What are the implications for policy and practice?

- This study shows it is important to investigate social and cultural contexts in order to understand suicidal behaviour.
- Religious leaders should be trained in suicide prevention support.
- Menal Health staff need to conduct holistic assessment of suicidal people that takes into account social and cultural issues that may trigger despair. Should not over-emphasise psychiatric conditions.
- Lack of social support cited as a major reason for suicidal behaviour - community groups / self-help groups that facilitate "social relations and connectivity among individuals in the community" could reduce suicide. p. 244

Appendix 3.4 Codebook, Sample (Study 1, Chapter 3)

Area	Analytical	Descriptive	Author	Country	Population	Income	Demographic	Type	Rating	Paper	Codes
Risk	Norms of Successful Male Selves Associated With Increased Suicide Risk	Failed Masculine Selves and Aversive Self-Awareness.	p.240, Akotia et al (2019)	Ghana	Attempted Suicide (Mixed)	Middle	Mixed	Secondary	Plus Plus	1	Thus, in a society where male virility, sexual prowess, and economic success define one's status, infidelity on the part of a wife could be humiliating to the husband (Adinkrah, 2010).
Risk	Norms of Successful Male Selves Associated With Increased Suicide Risk	Failed Masculine Selves and Aversive Self-Awareness.	p. 101, Kizza (2012)	Uganda	Bereaved (Mixed)	Lower	N/A	Primary	Plus Plus	33	In the Acholi culture roles are gendered, with men always regarded as the producer of wealth in the home and as the head of the family (El-Bushra & Sahl, 2005; Liu Institute for Global Issues, Gulu District NGO Forum & Ker Kwaro Acholi, 2005). Men are supposed to be in control of all the family resources, including children and wives. And for the rural men in Acholiland, land and live-stock were the source of their wealth. The women's major role was reproduction and to ensure food security in the home (El-Bushra & Sahl, 2005). In the advent of the war, movement in and out of the camp was restricted for men, rendering a significant number of men jobless, although others became casual laborers (Olaa, 2001).
Risk	Norms of Successful Male Selves Associated With Increased Suicide Risk	Failed Masculine Selves and Aversive Self-Awareness.	p. 259, Kunde (2018)	Australia	Bereaved (Male Suicide)	Upper	Farmers	Primary	Plus Plus	38	Themes provide a deeper insight into how depression and suicide among farmers are interconnected with rural masculine ideals of work, family, and the importance of emotional and physical strength, and the gender identities as a provider and protector.
Risk	Norms of Successful Male Selves Associated With Increased Suicide Risk	Failed Masculine Selves and Aversive Self-Awareness.	p. 703, Kizza 2012	Uganda	Bereaved (Male Suicide)	Lower	n/a	Secondary	Plus Plus	34	To achieve positive social status in Acholi culture, a man must provide for a family; otherwise, he may not be recognized as a ''man'' (Dolan, 2002, 2009) (...) Another virtue of an ideal Acholi man is to have control in his home, including of his wife and children (El-Bushra & Sahl, 2005). (...) in an ''ideal'' Acholi home the husband's authority is unquestionable. And, if the woman happens to overpower the man, that man is

											despised and regarded as the ‘‘woman’’ in the home. Given the crowded nature of the camp life, such disagreement could hardly go unnoticed by others. The deceased may have found this damage to his social identity to be unbearable.)
Risk	Norms of Successful Male Selves Associated With Increased Suicide Risk	Failed Masculine Selves and Aversive Self-Awareness.	p. 1211, Jordan (2012)	Northern Ireland	Suicidal Ideation, Attempted Suicide (Men)	Upper	Young	Primary	Plus Plus	29	Participants referenced a range of perceptions that contributed to their low self-esteem, levels of personal stress, and, ultimately, their increased risk for suicide (see Figure 2). The first perception was their understandings of what it was to be a successful man, which involved, among others, the following limiting constructs: that successful or “real” men have high-powered (meaningful) jobs, lots of money, access to girls, are certainly not gay are emotionally tough, do not need help, do not admit intrapersonal difficulties, and certainly do not admit to psychological problems:

Appendix 3.5 Coding Hierarchy (Study 1, Chapter 3)

Risk/Recovery	Analytical Theme	Descriptive Theme
Risk	Norms of Male Emotional Suppression	Emotional Suppression and Dysregulated Psychological Pain Childhood Adversities Affect Emotional Development Help-seeking Rejected as Weak Negative Experiences Accessing Mental Health Care Ineffective Coping Strategies Exacerbate Pain Suicide Associated with Intolerable Psychological Pain Suicide Associated with Hopelessness, Defeat and Entrapment
Risk	Failing to Meet Norms of Male Success	Failed Masculine Selves and Aversive Self-Awareness Performance of Self to Conceal Distress Childhood Adversities Affect Self-Esteem Suicide Associated with Killing of a Failed Self Suicide Associated with Regaining of Control
Risk	Norms that Suppress Men's Interpersonal Needs	Interpersonal Disconnection, Isolation and Loneliness Interpersonal Challenges and Dysregulation Struggling to Trust Suicide Associated with Interpersonal Stressors and Losses Suicide Associated with Unbearable Isolation and Loneliness Suicide Associated with Perceived Burdensomeness Proximal Indicators of Suicide Risk Challenging to Read
Recovery	Regulating Psychological Pain and Suicide Recovery	Emotional Regulation and Control Interpersonal Care and Connection Peer Connection and Expanding Masculine Selves Being Respected and Valued by Professionals Contextualized Suicidal Pain

Appendix 3.6 Key Findings (Study 1, Chapter 3)

Key Findings from Papers

First Author & Year	Country	Aim	Study Population	Sample Size	Methods	NICE Rating*	Key Findings in Relation to Review
Akotia et al. (2019)	Ghana	Reasons for attempting suicide among people hospitalized for a suicide attempt	Attempted Suicide (Mixed)	30	Interviews; IPA	++	Not given the family and social support that culture has taught them to expect; for men, specifically shame around not meeting cultural standards of masculinity; a sense of failure critical to suicide attempts; struggles with self-worth, failed ambition, disappointed in self, misused their life, self-evaluation very negative.
Akotia et al. (2014)	Ghana	To investigate the role of religion in people hospitalized for a suicide attempt	Attempted Suicide (Mixed)	30	Interviews; IPA	+	Failure to fulfil religious obligations; denouncing self after a failed attempt and letting down God; entrapment, high levels of hopelessness, feelings of shame that God has abandoned them, high social disconnect.
Andoh-Arthur et al. (2018)	Ghana	To explore the psychosocial circumstances of male deaths by suicide	Bereaved (Male Suicide)	43	Interviews; IPA	++	Suicide understood by bereaved relatives to have been driven in part by the shame of failing to meet masculine norms in relation to income provision, sexual performance and procreation.
Bell et al. (2010)	UK	To explore the role of perfectionism in students who died by suicide	Bereaved (Male Suicide); Young Men	N/A	Interviews; Grounded Theory	+	A desire and drive for perfection create a state of internal turmoil because standards can never be achieved, leaving male students vulnerable to devastating feelings of failure and high self-criticism that can become unbearable.
Benson et al. (2016)	UK	To develop a grounded theory of the process of suicide informed by lived experience	Attempted Suicide (Mixed) & Bereaved (Mixed)	54	Interviews; Grounded Theory	+	Suicidal process appeared to be driven by the interaction between a lack of perceived worth, a lack of trust in others, and suicidal exhaustion.
Biong & Ravndal (2007)	Norway	To understand suicidal behaviour in young men who also have long-term substance abuse	Attempted Suicide (Men); Young Men; Substance Abusers	4	Interviews; Hermeneutic Circle	++	Tension between moving between suicidal pain and the hope for a better life; childhood trauma impacts self-esteem; understanding of masculinity influences suicidal behavior; recovery anchored in building interpersonal connections which builds self-esteem.
Biong & Ravndal (2009)	Norway	To explore the experiences of emigration, substance abuse and suicidal behaviors in young non-western men	Attempted Suicide (Men); Young Men; Substance Abusers; Immigrants	4	Interviews, Hermeneutic Circle	++	Early life-stress; not belonging - caught between cultures; a sense of being socially dead; drugs as a way of escaping an unbearable reality; suicide as a release from pain; recovery anchored in revising thoughts about self, relationships and life possibilities.
Bonnewyn et al. (2014)	Belgium	To explore the process leading up to a suicide attempt in older adults	Attempted Suicide (Mixed); Elderly	8	Interviews; Grounded Theory	+	Life and self disrupted by loss; profound loneliness, anxiety, sleep issues, loss of mental control; suicidal participants exhausted and unwilling to continue with life.
Byng et al. (2015)	UK	To explore the pathways to suicide attempts and what leads some offenders, but not others, to attempt suicide	Men (Attempted Suicide and Not Suicidal); Prisoners	35	Interviews; Thematic Analysis	++	Unresolved trauma undermines coping resources; participants stuck in chaotic lives; overwhelming pain drives self-destructive behaviour.

Cavalcante & Minayo (2015)	Brazil	To explore pathways to a suicide attempt in older people	Attempted Suicide (Mixed); Elderly	60	Interviews	+	Depression from losses and abandonment; accumulated strain, stress and sorrow across the life course; suicide as escaping pain and loss of purpose.
Chung at al. (2015)	United States	To explore clinical and psychosocial factors contributing to suicide attempts Asian immigrant populations	Attempted Suicide (Mixed); Asian Immigrants	12	Mixed Methods (Life Charts & Interviews) Thematic Analysis	+	Childhood trauma; self-blame and self-stigma; lack of trust in others, isolation; feelings of failure. Recovery aided by building purpose, competency, agency and reciprocal caring dynamics.
Cleary (2005)	Ireland	To explore the motivation and contributing factors to suicide attempts in young men	Attempted Suicide (Men); Young Men	52	Interviews	++	Emotional suppression; engaging in masculine performances to not disclose or reveal distress; disclosure perceived as weaknesss; performing strength and concealing pain which takes toll on resources and wellbeing.
Cleary (2012)	Ireland	To explore the relationship between masculinity and suicidal behavior	Attempted Suicide (Men); Young Men	52	Interviews; Grounded Theory	++	Long-term pain, concealing distress, surveillance of male behaviour, coping with pain through alcohol and drugs which can compound despair; hopelessness as options for resolving pain diminish and mean men move towards suicide.
Costa & de Souza (2017)	Brazil	To explore drivers of suicide in older adults	Bereaved (Mixed); Elderly	11	Interviews	+	Accumulated losses over the life course, family conflict, signs of psychopathology and barriers accessing health services.
Creighton et al. (2017)	Canada	To investigate drivers of depression and suicide in rural men	Bereaved (Male Suicide); Rural Men	15	Interviews & PhotoVoice; Interpretive Descriptive Methods	++	Concealing depression; self-medicating though drink, drugs, fighting; prevention recommendations include new early intervention, education and new cultural norms of masculinity.
Crocker et al. (2006)	UK	To investigate the relationship between aging and suicide	Attempted Suicide (Mixed); Elderly	15	Interviews; IPA	++	Struggling to accept the loss of agency and status that comes with ageing; lost control over parts of their life; suicide as a way of taking back control; loss of visibility as growing isolation and loneliness.
Elliott-Groves (2018)	Canada	To explore drivers of suicide in the Cowichan community at the individual and collective level	Suicidal Ideation, Attempted Suicide, Bereaved (Mixed); Cowichan	21	Interviews; Grounded Theory & deductive approach using Interpersonal Theory of Suicide and Settler Colonial Theory	+	Acquired capacity to enact harm; Thwarted belongingness; Perceived burdensomeness; Loss of control; Loss of cultural belonging; Inequitable power and access resulting from colonialism.
Everall et al. (2006)	Canada	To understand how young people perceived the emotional experiences behind their previous suicidal behavior	Attempted Suicide (Mixed); Young People	50	Interviews; Grounded Theory	++	Suicidal feelings conceptualized as overwhelming despair; feelings of futility and defeat; feelings of worthlessness, shame and self-hate; perceived rejection from others, alienation and loneliness. Lack of tools to deal with emotions perceived to be related to suicide behavior.
Fenaughty et al. (2003)	New Zealand	To explore suicide resiliency in young gay men	Attempted Suicide, and Non-Attempts (Men); Young Men; Sexual Minority	8	Interviews; Grounded Theory	++	Resiliency built through positive representations of LGB community, family/peer/education/community acceptance and support; building up self-esteem.
Ferlatte et al. (2019)	Canada	To explore the perspectives of gay, bisexual and two-spirited	Suicidal Ideation, Attempted Suicide (Men) / Bereaved	29	Interviews & PhotoVoice; Thematic Analysis	++	The long-term impact of homophobia and biphobia and lack of long-term support; need queer-friendly services; peer support builds connection. Priorities for GBTSM prevention include tackling sexuality/gender/mental

		men (GBTSM) on suicide prevention	(Male Suicide); Sexual Minority				health stigma; accessible, ongoing, and GBTSM-positive therapy; reducing isolation through peer support and community involvement; building creativity and community resilience.
Ferlatte et al. (2019)	Canada	Examining how life paths and social factors contribute to the suicide vulnerability of gay, bisexual, and two-spirit (GB2SM) men	Suicidal Ideation, Attempted Suicide (Men); Sexual Minority	21	Interviews & PhotoVoice; Thematic Analysis	++	Negative experiences during childhood and adolescence; violence and homophobia had negative impacts on life opportunities and stability; stigma and isolation amplified suicidal pain.
Fitzpatrick (2014)	Australia	To explore how people who have attempted suicide understand and make sense of their actions	Attempted Suicide (Mixed)	12	Interviews; Narrative Analysis	++	Suicidal people understand their behaviour through the prism of the medicalisation of suicide and individual pathology. This framing stops suicidal people from incorporating social, cultural and political factors into their understanding of their despair.
Fogarty et al. (2018)	Australia	To investigate the tensions as perceived by at-risk men and their friends and family with regards suicide prevention	Attempted Suicide (Men) and Friends/Family	82	Interview & Focus Groups; Thematic Analysis	++	Tensions in suicide prevention include: balancing men's privacy with monitoring risk; distinguishing between typical and risky changes in behavior; weighing the desire to give men autonomy against the need to impose constraints to minimize risk, and acknowledging the need for external support services versus recognizing their shortcomings.
Gajwani et al. (2018)	UK	To explore the meaning of their suicide attempt in young men with first-episode psychosis	Attempted Suicide (Men); Young Men; Psychosis	7	Interviews; IPA	++	The pain of cumulative life events perceived to be unbearable; unresolved childhood trauma; social isolation; lost self; recovery anchored in rebuilding relationships and mattering to others.
Ghio et al. (2011)	Italy	To understand the experience, feelings and drivers of suicide attempts	Attempted Suicide (Mixed)	17	Focus Groups; Thematic Analysis	++	Suicide as escaping pain; guilt and disappointment post-attempt; empathy and care critical to recovery.
Gutierrez et al. (2015)	Brazil	To investigate the experiences of older people who have thoughts of suicide or attempted	Suicidal Ideation, Attempted Suicide (Mixed); Elderly	57	Interviews	+	Accumulated life losses; family tensions; feeling useless.
Hagaman et al. (2018)	Nepal	To explore social, cultural, and institutional drivers of suicide	Bereaved (Mixed)	N/A	Interviews; Thematic Analysis	++	Significant life stressors – poverty, lack of education, migration, violence, family conflict - resulting in isolation and internal shame; loss of social status; financial stress; men using alcohol to cope.
Han & Oliffe (2015)	Canada	To investigate help-seeking and suicide coping strategies in Korean-Canadian immigrants	Suicidal Ideation, Attempted Suicide (Mixed); Korean Immigrants	15	Interviews; Constant Comparative Analysis	+	Cultural shame attached to seeking psychological help; mental health attitudes in Korean communities create additional stigma.
Jordan et al. (2012)	UK	To explore young men's experiences of their suicide behaviors and how care could be improved	Suicidal Ideation, Attempted Suicide (Men); Young Men	36	Interviews; Grounded Theory	++	Expectations on men to be tough and deny weaknesses; protective value of family connection and mattering to others; more discrete mental health outreach in the community.
Kiamanesh et al. (2014)	Norway	To explore the relationship between perfectionism and suicide	Bereaved (Male Suicide)	41	Interviews; IPA	++	Potentially unhealthy drive for status and prestige; fear of failure and need for control; performance of self creates isolation and disconnection; suicide driven by a sense of defeat.

Kiamanesh et al. (2015)	Norway	To investigate the final stages of the suicide process in men identified as maladaptive perfectionists	Bereaved (Male Suicide)	41	Interviews; IPA	++	Cracks in performance of wellness, and unable to tolerate the loss of control; help-seeking not an option or disclosure of distress to others; suicide as escape from pain.
Kiamanesh et al. (2015)	Norway	To understand the conditions that could contribute to the development of maladaptive perfectionism in suicidal individuals	Bereaved (Male Suicide)	41	Interviews; IPA	++	Traumatic childhoods; unable to cope with perceived failure or weaknesses; fear of rejection.
Kizza et al. (2012)	Uganda	To investigate the relationship between alcohol use and suicide	Bereaved (Mixed)	N/A	Interviews; IPA	++	Alcohol as a driver of suicidal behaviour; loss of honour and dignity from not providing for the family; alcohol as a way to escape emotional pain.
Kizza et al. (2012)	Uganda	To explore psychosocial factors contributing to male suicide	Bereaved (Male Suicide)	62	Interviews; IPA	++	Lost dignity and social value; unbearable emotional pain; no hope for the family's future; diminished self-esteem.
Kjlseth et al. (2009)	Norway	To explore common patterns in the suicides of elderly people	Bereaved (Mixed); Elderly	63	Interviews; Systematic Text Condensation Method	++	Challenging childhoods; self-reliance; lack of trust in others; closed-off and potentially deprived of intimacy and meaningful connection.
Kjlseth et al. (2009)	Norway	To explore key experiences in the lives of elderly men prior to their death by suicide	Bereaved (Mixed); Elderly	63	Interviews; Systematic Text Condensation Method	++	Feelings of being a burden; perception that they had lost themselves; and death better than living.
Knizek & Hjelmeland (2018)	Norway	To explore the factors that men who had attempted suicide considered important in their decision to harm themselves	Attempted Suicide (Men)	15	Interviews; Qualitative Content Analysis	++	Relationship breakdowns diminish men's masculine capital; prevention and support need to consider cultural realities and expand beyond the bio-medical model.
Kunde et al. (2018)	Australia	To investigate suicide in Australian male farmers	Bereaved (Male Suicide); Farmers	12	Interviews; Thematic Analysis	++	Norms of masculinity and emotional concealment; feeling a failure; lack of control; maladaptive coping strategies.
Laubschler (2003)	South Africa	To investigate how bereaved significant others understand male suicide in a town in South Africa	Bereaved (Male Suicide)	11	Interviews; Qualitative, Interpretative Analysis.	+	Cultural changes; community breakdown; loss of traditional coping tools.
Lusk at al. (2018)	United States	To explore the relationship between spiritual and/or religious struggles in veterans at risk of suicide	Suicidal Ideation, Attempted Suicide (Mixed); Veterans	30	Interviews; Thematic Analysis	+	Spirituality and religion can either discourage or allow for suicidal thoughts, aid in managing those thoughts, and help with finding meaning and coping during periods of perceived distress.
Mackenzie at al. (2018)	UK	To investigate the experiences of probation clients who have attempted suicide	Attempted Suicide (Mixed); Probation Clients	7	Interviews; IPA	++	Accumulated life losses; difficulties in trusting others; perceived to have lost control in key areas of life; recovery anchored in regaining control; building purpose meaning; learning to trust and create meaningful dynamics.
McAndrew & Warne (2010)	UK	To explore the experiences that contribute to suicide in gay men	Suicidal Ideation, Attempted Suicide	4	Free Association Narratives	++	Unmet needs in childhood; being an outsider; loneliness; performance of self undermines psychological stability and leads to a fragmented self; self-harm behaviours.

			(Men); Sexual Minority		Interviews and Analysis		
Meissner & Bantjes (2017)	South Africa	To explore how young men made sense of the experiences leading up to their suicide attempt and experiences recovering from those feelings	Attempted Suicide (Men); Young Men	4	Interviews; IPA	++	Disconnection from self and others - conflict at home, isolation, shame, pain, feeling trapped; Coping strategies that compound disconnection - self-harm, drinking, isolation, suicide as regaining control; reconnecting with self and others - recovery about finding purpose, reconnecting with others, being of value to people.
Meneghel et al. (2012)	Brazil	To explore the relationship between suicide, aging and gender	Bereaved (Mixed); Elderly	50	Interviews	+	Gendered codes for behaviour; masculine emphasis on autonomy, control, independence, emotional suppression - loss of masculine control as men got older, more dependent and lost provider status; suicide as a way of regaining control.
Oliffe et al. (2017)	Canada	To explore the relationship between masculinity and suicide	Suicidal Ideation, Attempted Suicide (Men)	20	Interviews & PhotoVoice; Constant Comparison	++	Childhood challenges, cumulative pain impacting self-esteem, feeling inadequate, no resources to change things, isolation, pain relief through drink, hopelessness - suicide as a pain-ending strategy.
Oliffe et al. (2018)	Canada	To investigate the relationship between masculinities and suicide bereavement among men who have lost a man to suicide	Bereaved (Male Suicide)	20	Interviews & PhotoVoice; Constant Comparison	++	Two categories of suicides – unforeseen and rationalized. Unforseen suicides where the pain was kept inside and invisible. Rationalized suicides described a range of preexisting risk factors, including mental illness and substance abuse. An overarching theme of "managing emotions", where men were understood to not be given the same tools around emotions as women.
Oliffe et al. (2019)	Canada	To explore experiences of social isolation in men with a history of suicide	Suicidal Ideation, Attempted Suicide (Men)	35	Interviews & PhotoVoice; Constant Comparison	++	Social isolation holds multiple roots including childhood challenges and family dysfunction; feeling like a misfit, lack of belonging, alienation; bad experiences with mental health professionals and medication bias; ineffective coping through self-harm; self-stigma because of sexual identity or mental health.
Orri et al. (2014)	Italy	To understand the experiences of adolescents who have attempted suicide	Attempted Suicide (Mixed); Young People	16	Interviews; IPA	+	Suicide factors described as including devalued self; shame and guilt; lack of control in life; interpersonal stresses; lack of trust in others.
Osafo et al. (2015)	Ghana	To explore the experiences of people who have attempted suicide	Attempted Suicide (Men)	10	Interviews; Thematic Analysis	+	Hopelessness, unable to provide for the family; shame of partners infidelity; social stigma towards suicide attempters; interpersonal relationships and religion can all help with coping.
Owen et al. (2012)	UK	To investigate the challenges experienced by significant others in recognizing signs of suicide and determining whether and how to take action	Bereaved (Mixed)	31	Interviews; Communication Pragmatics and Face-Work Theory.	++	Suicide often disclosed in ambiguous and indirect ways making it hard to interpret intent, limiting potential responses.
Owens et al. (2005)	UK	To investigate the decision-making processes of distressed individuals and their loved ones regarding seeking or avoiding help from a medical practitioner in the period before a suicide	Bereaved (Mixed)	66	Interviews; Thematic Analysis	+	Strengthening significant others as a suicide recovery resource; mental health literacy skills; working in collaboration with professionals.

Owens et al. (2011)	UK	To explore the challenges significant others face interpreting signs of suicidality and deciding whether and how to intervene	Bereaved (Mixed)	31	Interviews; Narrative and Thematic Analysis	++	Signs are difficult to interpret for complex reasons and because of intimate and emotional investment in the distressed person. Need more support for significant others as frontline responders to suicidal crises; tools to identify risk and protect their own well-being.
Owens et al. (2008)	UK	To examine how parents make sense of their sons' suicide	Bereaved (Male Suicide); Young Men	14	Interviews	+	Diversity of narratives - son as victim of external forces versus son as agents of destruction. In some instances, parents depict their sons as victims who were ruthlessly taken down by outside influences and people, while in other cases they view them as being responsible for their own demise.
Pavulans et al. (2012)	Sweden	To explore the experiences of people who are suicidal with the goal of identifying potential insights that could be relevant for healthcare professionals	Attempted Suicide (Mixed)	10	Interviews; Qualitative content analysis	++	Lost control; unable to direct thoughts or emotions; overwhelm; life spinning out of control; suicide as a way out of pain; recovery anchored in giving suicidal people back a sense of control.
Peters et al. (2013)	Australia	To investigate the events in the lead up to a loved ones death by suicide	Bereaved (Male Suicide)	10	Interviews; Thematic Analysis	++	Acute pressures on significant others caring for a man who is suicidal; concerns not acknowledged by health services; service response inadequate; exclusion of significant others by health professionals.
Player et al. (2015)	Australia	To investigate the various factors that may facilitate, impede or hinder interventions aimed at men who at risk and also elucidate the roles that significant others may play in preventing male suicide	Attempted Suicide (Men)	82	Interviews & Focus Groups; Thematic Analysis	++	Norms of male stoicism, emotional suppression; loss of control; short term pain-relief (drink, drugs); interpersonal problems; increased isolation and despair. Recovery around supporting friends and family to understand risk signs and supporting men to understand and manage their distress.
Rasmussen et al. (2014)	Norway	To investigate warning signs of suicide in young men	Bereaved (Male Suicide); Young Men	61	Interviews; IPA	++	Young men did not directly express plans of suicide or ask for help. Indirect signs were communicated including rumination on perceived irreversible mistakes, desperation, death as a threat, and death as a destination.
Rasmussen et al. (2018)	Norway	To explore the relationship between self-esteem and suicide in young men	Bereaved (Male Suicide); Young Men	61	Interviews; IPA	++	Struggling to transition into adulthood; diminished self-esteem; sense of failure; emotional suppression; isolation; unbearable pain.
Rasmussen & Dieserud (2018)	Norway	To explore bereaved loved one's experiences of detecting suicide risk and motivating young men to seek support	Bereaved (Male Suicide); Young Men	61	Interviews; IPA	++	Framing of suicide as a mental illness problematic; suicide related to interpersonal, relational factors; need to expand the bio-medical model of suicide.
Rasmussen et al. (2018)	Norway	To investigate the meanings of masculinity provoked by the suicides of young men	Bereaved (Male Suicide); Young Men	61	Interviews; IPA	++	Losing hope; failing to meet masculine standards; emotional suppression; childhood challenges; unmet emotional needs; lack of self-worth; performance of self; weakness not allowed, suicide as heroic.
Ribeiro et al. (2016)	Brazil	To investigate the drivers of suicide in men who use alcohol and other drugs	Attempted Suicide (Men)	11	Interviews; Phenomenological Sociology of Alfred Schütz	+	Attempted suicide triggered by alcohol and drug use; feeling a burden to family; loss of status and feelings of failure as a man; losses accrued across the life course.

River (2018)	Australia	To generate a theory of help-seeking practices within men who are suicidal	Attempted Suicide (Men)	18	Interviews; Life History Method	++	Complexity of men's relationships with help-seeking; lack of control in treatment plans; professionals also socialised in masculine norms and misread male distress; rejection of services that perceived distress as an illness.
Rivers et al. (2018)	UK	To explore risk and protective factors of LGBT people who attempted suicide in their youth	Attempted Suicide (Mixed); Sexual Minority	17	Interviews; Thematic Analysis	+	Early-life challenges, burden of homophobia; lack of belonging; interpersonal stressors.
Rivlin at al. (2013)	UK	To explore the psychological challenges and drivers leading up to and following a suicide attempt	Attempted Suicide (Men); Prisoners	60	Interviews; Thematic Analysis	++	Accumulation of life challenges; calm and relief in planning suicide; counselling support desired in helping to understand emotions; recovery supported by being listened to and valued.
Rivlin et al. (2013)	UK	To create a typology to understand the suicidal behaviour of male prisoners	Attempted Suicide (Men); Prisoners	60	Interviews; Thematic Analysis	++	Struggling to cope in prison; Childhood Abuse; Withdrawing from drugs. Five subgroups of suicide attempts: (1) prisoners being unable to cope in prison, (2) psychotic symptoms, (3) instrumental motives, (4) attempts that were "unexpected" by the prisoners themselves, and (5) attempts associated with drug withdrawal.
Salway & Gesink (2018)	Canada	To document the stories of gay men who attempted suicide as adults	Attempted Suicide (Men); Sexual Minority	7	Interviews; Dialogical Narrative Analysis	++	Pride narratives that refuse to acknowledge any connection between the suicide and sexuality. Trauma-and-stress narratives, that recognize the role of sexual stigma, depression from rejection. Memorial narratives that aim to prevent suicide by maintaining a strong sense of identity. Additional risk of suicide among older generations of gay men who feel excluded from modern gay movements.
Sellin et al. (2017)	Sweden	To understand how recovery is experienced by persons at risk of suicide	Attempted Suicide (Mixed)	14	Interviews; Reflective Lifeworld	++	Recovery described in parts as being able to give voice to oneself; regaining dignity through connections; oscillating between life and death and navigating that tension.
Stanley et al. (2009)	UK	To investigate risk factors prevalent in the suicides of students	Bereaved (Mixed); Young People; Students	20	Interviews; Grounded Theory	+	Fear of failure; perfectionism; mistrust of medication; interpersonal stressors; suicide as protecting the self.
Strike et al. (2006)	Canada	To explore how men who are suicidal interact with mental health services	Attempted Suicide (Men); Clinical	15	Interviews; Thematic Analysis	++	Negative cycles of bad experiences accessing care and then avoiding; men described childhood challenges, emotional suppression, substance abuse; stigmatised by the healthcare system and some staff; underlying emotional challenges not addressed by care; some men put off by medical bias.
Sweeney et al. (2015)	Ireland	To explore how young men interpreted and responded to behaviour changes in a friend before their suicide	Bereaved (Male Suicide); Young Men	15	Interviews; Thematic Analysis	++	Complexity of managing and responding to suicide disclosure - emotional suppression; revealing a problem when drunk; hard to interpret behaviours.
Tryggvadottir et al. (2019)	Iceland	To investigate experiences of suicide in male abuse survivors	Suicidal Ideation (Male); Abuse Survivors	7	Interviews; Vancouver School of Doing Phenomenology	++	Decimated self-esteem; emotional suppression; isolation; loneliness; suicide as escaping self and pain.
Tzeng (2001)	Taiwan	To explore how people experience life following a suicide attempt	Attempted Suicide (Mixed); Clinical	10	Interviews; Thematic Analysis	+	Entrapment; emotional chaos; loss of control; interpersonal stressors; lack of belonging.

Vatne & Naden (2012)	Norway	To investigate the experiences following a suicidal crisis	Attempted Suicide (Mixed)	10	Interviews; Thematic Analysis	++	Shame; guilt; isolation; lack of interpersonal tools; struggling between life and death; life challenges.
Vatne & Naden (2014)	Norway	To explore the aftermath of a suicide attempt and what patients perceive as having helped them	Attempted Suicide (Mixed)	10	Interviews; Thematic Analysis	++	Different experiences described – participants who were met with openness and trust; participants whose concerns were met or not; being met as an equal or with shame.
Vatne & Naden (2016)	Norway	To explore the experiences of people in contact with psychiatric healthcare following a suicide attempt	Attempted Suicide (Mixed)	10	Interviews; Thematic Analysis	++	Recovery supported via experiencing connection; being listened to and respected; becoming aware of responsibilities to others.
Vatne & Naden (2018)	Norway	To investigate what people who have attempted suicide see as meaningful in terms of care and treatment	Attempted Suicide (Mixed)	10	Interviews; Thematic Analysis	+	Being respected and valued by professionals; peer connection; experiencing hope; taking back responsibility; mutual trust.
Wiklander et al. (2003)	Sweden	To explore the relationship between shame and care following a suicide attempt	Attempted Suicide (Mixed)	13	Interviews; Thematic	+	Experiencing vulnerability and shame following a suicide attempt; feeling ashamed of oneself due to the attempt; urges to hide or escape from the situation; experiencing care from staff could help alleviate shame.
Ziółkowska & Galasiński (2017)	Poland	To investigate the narrative of children who lost their fathers to suicide	Bereaved (Male Suicide)	10	Interviews; Critical Discourse Analysis	+	Alcoholism; unable to manage problems; loneliness; suicide as escape.

Appendix 3.7 Supporting Evidence Index (Study 1, Chapter 3)

Index of Papers with Supporting Thematic Evidence

Theme Type	Theme Name	Papers With Supporting Thematic Evidence
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Paper Identification. 1 = Akotia et al. (2019); 2 = Akotia et al. (2014) 3 = Andoh-Arthur et al. (2018); 4 = Bell et al. (2010); 5 = Benson et al. (2016); 6 = Biong & Ravndal (2007); 7 = Biong & Ravndal (2009); 8 = Bonnewyn et al. (2014); 9 = Byng et al. (2015); 10 = Cavalcante & Minayo (2015); 11 = Chung at al. (2015); 12 = Cleary (2005); 13 = Cleary (2012); 14 = Costa & de SouzaII (2017); 15 = Creighton et al. (2017); 16 = Crocker et al. (2006); 17 = Elliott-Groves (2018); 18 = Everall et al. (2006); 19 = Fenaughty et al. (2003); 20 = Ferlatte et al. (2019); 21 = Ferlatte et al. (2019); 22 = Fitzpatrick (2014); 23 = Fogarty et al. (2018); 24 = Gajwani et al. (2018); 25 = Ghio et al. (2011); 26 = Gutierrez et al. (2015); 27 = Hagaman et al. (2018); 28 = Han & Oliffe (2015);

29 = Jordan et al. (2012); 30 = Kiamanesh et al. (2014); 31 = Kiamanesh et al. (2015); 32 = Kiamanesh et al. (2015); 33 = Kizza et al. (2012); 34 = Kizza et al. (2012); 35 = Kjlseth et al. (2009); 36 = Kjlseth et al. (2009); 37 = Knizek & Hjelmeland (2018); 38 = Kunde et al. (2018); 39 = Laubschler (2003); 40 = Lusk at al. (2018); 41 = Mackenzie at al. (2018); 42 = McAndrew & Warne (2010); 43 = Meissner & Bantjes (2017); 44 = Meneghel et al. (2012); 45 = Oliffe et al. (2017); 46 = Oliffe et al. (2018); 47 = Oliffe et al. (2019); 48 = Orri et al. (2014); 49 = Osafo et al. (2015); 50 = Owen et al. (2012); 51 = Owens et al. (2005); 52 = Owens et al. (2011); 53 = Owens et al. (2008); 54 = Pavulans et al. (2012); 55 = Peters et al. (2013); 56 = Player et al. (2015); 57 = Rasmussen et al. (2014); 58 = Rasmussen et al. (2018); 59 = Rasmussen & Dieserud (2018); 60 = Rasmussen et al. (2018); 61 = Ribeiro et al. (2016); 62 = River (2018); 63 = Rivers et al. (2018); 64 = Rivlin at al. (2013); 65 = Rivlin et al. (2013); 66 = Salway & Gesink (2018); 67 = Sellin et al. (2017); 68 = Stanley et al. (2009); 69 = Strike et al. (2006); 70 = Sweeney et al. (2015); 71 = Tryggvadottir et al. (2019); 72 = Tzeng (2001); 73 = Vatne & Naden (2012); 74 = Vatne & Naden (2014); 75 = Vatne & Naden (2016); 76 = Vatne & Naden (2018); 77 = Wiklander et al. (2003); 78 = Ziółkowska & Galasiński

Appendix 3.8 Additional quotes illustrating the interaction of emotions, self and interpersonal connections (Study 1, Chapter 3)

Interaction of:	Supporting Evidence
Emotions and Self	"A continual negative relationship to the self [self-aversion] seemed to influence both their earlier and current troubles and created emotional problems for the participants in their daily lives [emotional dysregulation]." (p. 251, Biong & Ravndal, 2007) "In the context of this surveillance, continuous self-monitoring of behaviour and emotions was required to project an image of well-being [performance of self/emotional suppression]. 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 [emotional dysregulation]" (p. 502, Cleary, 2012) "Informants also mentioned the strong social pressures, especially among young men, to hide distress [emotional suppression] and keep up a pretence of coping [performance of self]". (p. 3, Owens et al., 2011)
Emotions and Interpersonal Connections	"There is no one who understands my feelings [interpersonal isolation]. I have hidden my problems from others [emotional suppression]. As a result, I have never asked for help, and I do feel very lonely [interpersonal isolation]." (p. 359, Chung at al., 2015) "More so, for some participants aligning to the aforementioned masculine ideals prevented them from seeking help from their social network [emotional suppression] - which in turn resulted in social isolation [interpersonal isolation]." (p. 1538, Ferlatte et al., 2019) "Many men stated that their attempts to manage problems to avoid revealing weakness [emotional suppression], or stigmatising labels led them to isolate themselves [interpersonal isolation] and instead rely on coping strategies that required less immediate effort and provided short-term alleviation of problems, for example, drug or alcohol use, gambling, and working excessively. However, these strategies repeatedly made problems worse in the long term through, for example, debt creation, and emotional reaction and interpersonal conflicts [emotional/interpersonal dysregulation]." (p. 5, Player et al., 2015)

Self and Interpersonal Connections	"For men, economic difficulties mean loss of self-worth [self-aversion], lack of recognition and respect from society, equally becoming outcasts [interpersonal isolation]" (p. 243, Akotia et al., 2019) "Our findings suggest that relationship breakdown [interpersonal challenges] is associated with feelings of failure and shame [self-aversion] with lack of trusted supports [interpersonal isolation]." (p. 259, Kunde et al., 2018) "I always used to stay in bed and say I hate myself [self-aversion]. I wouldn't take a bath for days . . . I wouldn't go out. I wouldn't even socialize with people [interpersonal isolation]." (p. 33, Strike et al., 2006)
Emotions, Self and Interpersonal Connections	"The participants believed that disconnecting from others and the self [isolation from self and others] was a viable technique for managing painful emotions and thoughts [norms of male emotional regulation]. However, in hindsight, participants recognised that disconnecting from others and themselves intensified the emotions that they sought to control and thus it became a trigger for suicidal behaviour [emotional dysregulation]." (p. 792, Meissner & Bantjes, 2017) "Thus, common to all the deceased, from whoever's perspective one examines it, was a lack of capacity to handle emotional distress or chaos [emotional dysregulation], and a tendency to act upon oneself. Described by many of their parents as "private" young men, several siblings said "we never had deep conversations." [interpersonal isolation] Their friends described them as someone who "did not show emotions," "kept difficulties inside," [emotional suppression] or "not the one we discussed emotional difficulties with." [interpersonal distance] According to their ex-girlfriends, although some were described as "very emotional" young men, when things were difficult "they withdrew," or were "emotionally elusive." [emotional suppression] Thus, common in all informants' understanding was a lack of self-regulation [dysregulation of self]." (p. 229, Rasmussen et al., 2018)

Appendix 4.1 Participant Information Sheet (Study 2, Chapter 4)

University of Glasgow | College of Medical, Veterinary & Life Sciences

PARTICIPANT INFORMATION SHEET.

Study Title: Understanding suicide risk factors in men.
Researcher: Susie Bennett, Institute of Health and Wellbeing, University of Glasgow.
Supervisors: Professor Rory O'Connor and Dr Katie Robb.

Thank you so much for considering taking part in this research project.

This study aims to explore sensitive topics and so it is crucial you feel comfortable about taking part and with sharing your experiences. This information sheet is to help you make an informed decision about whether you want to participate. It will give you an overview of the purpose of the research, what your participation will involve and your right to withdraw at any time. Given the emotional nature of the research, you may have further questions or concerns prior to taking part. Please feel free to contact me to discuss anything in more detail. My email is: s.bennett.2@research.gla.ac.uk

This study will be open for responses between March and September 2021. Take your time reading this information sheet, don't feel rushed and remember, there is no obligation to take part.

Thank you.

What is the purpose of this study? The purpose of this study is to explore some of the factors that put at men at risk of suicidal thoughts, feelings and behaviours. Even if you have never had suicidal thoughts or feelings, your answers will help provide vital insight.

Why have I been invited to participate? You responded to an advert about the research, and you identify as male and are aged over 18.

Do I have to take part? You are under no obligation to take part in this study; doing so is completely your own decision.

What will happen to me if I take part? For this study, you will be required to complete an online questionnaire, which will take approximately 25 minutes. You can complete this on any internet-enabled device in a place and time of your choosing.

What are the possible benefits of taking part? Male suicide rates represent a significant public health crisis. However, academic research into what causes male suicide and how to reduce it is surprisingly lacking. This lack of research leaves vital gaps in our understanding of why so many men die by suicide in Britain and what more can be done to prevent it. The information you provide will help provide a better understanding of the factors that put men at risk of suicidal thoughts and behaviours. Findings will be shared with all key stakeholders involved in suicide prevention in the UK. In doing so, we hope this research can influence and inform policy, clinical practice, and suicide theory.

What are the possible disadvantages and risks of taking part? During the questionnaire, we would like you to answer a series of questions about different topics, including your childhood, your emotions, mental pain, and suicidal thoughts and feelings. Some of the questions may be distressing especially if you are currently

experiencing suicidal feelings. During the survey, we will provide contact details of organisations who could provide support for you as well as at the end of this information sheet. We are very sorry that you currently feel this pain and we hope that answers from this survey will help provide even better support for people feeling similarly in the future. Remember you are under no obligation to take part, your wellbeing is the priority.

Will my taking part in this study be kept confidential? All of the responses that you provide will be kept strictly confidential. No identifying information will be collected beyond simple demographic data, and you cannot be recognised from your responses. All data will be collected in electronic format, and will be stored on secure password–protected computers. No one outside of the research team or appropriate governance staff will be able to find out your responses.

What will happen to my data? All responses to the questionnaire will be stored in a password protected Microsoft Excel spreadsheet and RStudio script securely on the University of Glasgow network. All study data will be held in accordance with the General Data Protection Regulation (2018). Nobody outside of the research team will have access to this data, and it will be stored in archiving facilities in line with the University of Glasgow retention policy of up to 10 years. After this period, further retention may be agreed or your data will be securely destroyed in accordance with the relevant standard procedures.

What will happen to the results of the study? The results of the study will be used for my PhD, shared with people involved in suicide prevention work and submitted for publishing by peer-reviewed journals.

Who is organising and funding the study? The study is being organised by Susie Bennett (researcher) and supervised by Professor Rory O'Connor & Dr Katie Robb. It is not being funded by any company, charity, organisation or research council.

Who has reviewed the study? The study has been reviewed by the College of Medical, Veterinary & Life Sciences Ethics Committee.

Contact for Further Information. If you have any questions or require more information please contact Susie Bennett on s.bennett.2@research.gla.ac.uk

Thank you for taking the time to read this information sheet.

SUPPORT ORGANISATIONS

1. **SUPPORT FOR PEOPLE EXPERIENCING SUICIDAL THOUGHTS AND FEELINGS.**

At some time in all of our lives, we feel down, depressed or low. If you are feeling down, or are worried about something and would like to speak to someone, please see the list of organisations below. You may also wish to contact your GP or another healthcare professional.

If you think your life or someone's life is in danger you should visit an emergency department or call an ambulance by dialling 999.

NHS 24. Health Information and Self Care Advice

NHS 24 provides comprehensive up-to-date health information and self-care advice. If your GP surgery is closed and you can't wait until it opens, you can call NHS 24. They will direct you to the right care for you or the person you are calling for. This may be to your local Health Board's out of hours services, Accident and Emergency department, or the Ambulance Service. If appropriate, they may recommend some steps you can take to look after yourself at home.
https://www.nhs.uk - Tel: 111

Samaritans

Samaritans is a support service available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide. https://www.samaritans.org/ - Tel: 08457 90 90 90

CALM (campaign against living miserably)

CALM is leading a movement against suicide, with a particular focus on men who are often more at risk. They have a national helpline, webchat and online resources for support
www.thecalmzone.net Helpline 0800 58 58 58 - London 080 802 58 58 OPEN 7 days a week 17.00-00.00
Email info@thecalmzone.net - Webchat www.thecalmzone.net/help/webchat/

PAPYRUS

This is a national charity which helps to stop young suicide. They run HOPELineUK. HOPELineUK give practical advice and information to: children, teenagers and young people up to the age of 35 who are worried about how they are feeling, and anyone who is concerned about a young person.
https://www.papyrus-uk.org - Telephone: 0800 068 41 41 (open Mon-Fri: 10am to10pm, weekends: 2pm to 10pm & bank holidays: 2pm to 5pm) - SMS: 07786 209697 - Email: pat@papyrus-uk.org

The Mix

They offer a free, confidential helpline service for young people under 25.
Telephone: 0808 808 4994 (Open 11am – 11pm 7 days a week) E-mail:
www.getconnected.org.uk/email-us/
Webchat: through the website: www.getconnected.org.uk

Men's Minds Matter

Men's Minds Matter is a not-for-profit organisation dedicated to the prevention of male suicide by building psychological resilience and emotional strength. The website has many resources and guides relating to male suicide including anger, stress, depression and how to support a man in crisis.
Website: https://www.mensmindsmatter.org/

Andy's Club

Andy's Club are talking club's for men. They have numerous clubs across the country and a national online group for those outside of current club catchment areas.
Website: https://andysmanclub.co.uk/

Men Speak Global

"At MenSpeak, we create spaces for men who want more out of life. We practice dropping our 'nice guy', 'macho man' or whatever masks we wear, as we talk openly and honestly about what's up in our lives, at our own pace and in our own time. There's no pressure to speak and we never tell each other what to do or how to be. Instead, we respectfully question and challenge one another to acknowledge who we've been and test-drive who we want to be, taking the best of ourselves back out into the world."
Website: https://mensgroups.co.uk/

Man Health (Northumberland)

ManHealth provide free peer support groups and a WebChat and Connect service across County Durham and Northumberland for men with depression and other mental health conditions.
Website: https://www.manhealth.org.uk/

Maytree (London)

Maytree's house is open 365 days a year for people when they're feeling suicidal. Maytree provide a unique residential service for people in suicidal crisis so they can talk about their suicidal thoughts and behaviour. They offer a free 4 night, 5 day one-off stay to adults over the age of 18 from across the UK.
Website: https://www.maytree.org.uk/

The Listening Place (London)

Face-to-face support for those who feel life is no longer worth living. Carefully trained and selected volunteers, working in a supportive environment and backed by experienced mental health professionals, have regular meetings with people who are struggling with suicidal thoughts, plans and actions.
Website: https://listeningplace.org.uk/

James Place (Liverpool)

James' Place, work with men who are experiencing a suicidal crisis. Their centre in Liverpool supports men from Merseyside who are referred by health professionals or have self-referred.
Website: https://www.jamesplace.org.uk/

Sean's Place (Liverpool)

Sean's Place aim is to improve men's mental health and well-being across Sefton and Liverpool City Region through sessions specifically identified to improve confidence and self-esteem for men whilst reducing symptoms of depression, stress and anxiety.
Website: https://seansplace.org.uk/

2. ADDITIONAL SUPPORT LINES

Alcohol Change

Alcohol Change UK is a UK alcohol charity. Their website links to a wide range of support services should you wish to speak to or get advice about your drinking. https://alcoholchange.org.uk/

Smokeline

Smokeline is Scotland's national stop smoking helpline, open every day from 8am-10pm. They have helped thousands of people and can help you too. Smokeline advisers can guide you through what's helped other smokers, and help you work out what's most likely to work for you.
http://www.canstopsmoking.com/ - Tel: 0800 848 84 84

National Debtline

Provides free, independent, confidential advice on a self-help basis. You can contact them over the telephone, by e-mail or letter.
www.nationaldebtline.org - Telephone: 0808 808 4000 Monday to Friday 9am-8pm and Saturday 9.30am-1pm
Email: visit website to use email contact form

Switchboard – LGBT + Helpline

Switchboard gives practical and emotional support for lesbian, gay, bisexual or transgender people. You can talk to them about any issue.
Webchat: through the website - www.switchboard.lgbt - Telephone: 0300 330 0630 (open 10am – 11pm)
E-mail: chris@switchboard.lgbt

Appendix 4.2 Consent Form (Study 2, Chapter 4)

College of Medical, Veterinary & Life Sciences Ethics Committee for Non-Clinical Research Involving Human Subjects

Title of Project: Understanding suicide risk factors in men.

Name of Researcher: Susie Bennett

Please read the following statements. Place a tick/check in the box if you would like to participate.

- I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
- I confirm that I agree to the way my data will be collected and processed and that data will be stored for up to 10 years in University archiving facilities in accordance with relevant Data Protection policies and regulations.
- I understand that all data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers.
- I am male and aged 18 years of age or over.

☐ Yes, I agree to take part in this study.

☐ No, I do not agree to take part in this study

Appendix 4.3 Survey Constructs (Study 2, Chapter 4)

Measure	Survey Question	Variable type	Range	items
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	1. Little interest or pleasure in doing things	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	2. Feeling down, depressed, or hopeless	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	3. Trouble falling or staying asleep, or sleeping too much	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	4. Feeling tired or having little energy	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	5. Poor appetite or overeating	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	7. Trouble concentrating on things, such as reading the newspaper or watching television	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	9. Thoughts that you would be better off dead or of hurting yourself in some way	Scale	0-3	0. Not at all; 1. Several days; 2. More than half the days; 3. Nearly every day
Depression Patient Health Questionnaire (PH-9; Kroenke, Spitzer & Williams, 2001)	If you checked off any problem listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Scale	1-4	1. Not difficult at all; 2. Somewhat difficult; 3. Very difficult; 4. Extremely difficult
2 items (Emotional Control and Self Reliance) from Conformity to Masculine Norms (Mahalik et al., 2020)	1. I tend to share my feelings	Scale	1-6	1. Strongly Disagree; 2. Disagree; 3. Slightly Disagree; 4. Slightly Agree; 5. Agree; 6. Strongly Agree
2 items (Emotional Control and Self Reliance) from Conformity to Masculine Norms (Mahalik et al., 2020)	2. It bothers me when I have to ask for help	Scale	1-6	1. Strongly Disagree; 2. Disagree; 3. Slightly Disagree; 4. Slightly Agree; 5. Agree; 6. Strongly Agree
2 items (Emotional Control and Self Reliance) from Conformity to Masculine Norms (Mahalik et al., 2020)	3. I bring up my feelings when talking to others	Scale	1-6	1. Strongly Disagree; 2. Disagree; 3. Slightly Disagree; 4. Slightly Agree; 5. Agree; 6. Strongly Agree
2 items (Emotional Control and Self Reliance) from Conformity to Masculine Norms (Mahalik et al., 2020)	4. I like to talk about my feelings	Scale	1-6	1. Strongly Disagree; 2. Disagree; 3. Slightly Disagree; 4. Slightly Agree; 5. Agree; 6. Strongly Agree
2 items (Emotional Control and Self Reliance) from Conformity to Masculine Norms (Mahalik et al., 2020)	5. I never ask for help	Scale	1-6	1. Strongly Disagree; 2. Disagree; 3. Slightly Disagree; 4. Slightly Agree; 5. Agree; 6. Strongly Agree

2 items (Emotional Control and Self Reliance) from Conformity to Masculine Norms (Mahalik et al., 2020)	6. I am not ashamed to ask for help	Scale	1-6	1. Strongly Disagree; 2. Disagree; 3. Slightly Disagree; 4. Slightly Agree; 5. Agree; 6. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	1. I think getting emotional is a sign of weakness.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	2. Turning to someone else for advice or help is an admission of weakness.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	3. It is shameful for a person to display his or her weaknesses.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	4. People will reject you if they know your weaknesses.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	5. If a person asks for help it is a sign of weakness.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	6. When I am upset I bottle up my feelings.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	7. When I am upset I usually try to hide how I feel.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	8. I seldom show how I feel about things.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	9. When I get upset I usually show how I feel.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	10. I do not feel comfortable showing my emotions.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	11. I think you should always keep you feelings under control.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	12. I think you ought not to burden other people with your problems.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	13. You should always keep your feelings to yourself.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	14. You should always hide your feelings.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	15. I should always have complete control over my feelings.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	16. I think other people do not understand your feelings.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	17. Other people will reject you if you upset them.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	18. My bad feelings will harm other people if I express them.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	19. If I express my feelings I am vulnerable to attack.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Attitudes towards Emotional Expression scale (Joseph et al., 1994)	20. If other people know what you are really like, they will think less of you.	Scale	1-5	1. Strongly Disagree; 2. Disagree; 3. Neutral; 4. Agree; 5. Strongly Agree
Entrapment Scale (De Beurs et al., 2020)	1. I often have the feeling that I would just like to run away.	Scale	1-5	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me

Entrapment Scale (De Beurs et al., 2020)	2. I feel powerless to change things	Scale	1-5	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me
Entrapment Scale (De Beurs et al., 2020)	3. I feel trapped inside myself.	Scale	1-5	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me
Entrapment Scale (De Beurs et al., 2020)	4. I feel I'm in a deep hole I can't get out of	Scale	1-5	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me
4 items (Defeat) from Defeat & Entrapment Scale (Griffiths et al., 2015)	1. I feel defeated by life	Scale	1-5	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me
4 items (Defeat) from Defeat & Entrapment Scale (Griffiths et al., 2015)	2. I feel powerless	Scale	1-5	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me
4 items (Defeat) from Defeat & Entrapment Scale (Griffiths et al., 2015)	3. I feel that there is no fight left in me	Scale	1-5	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me
4 items (Defeat) from Defeat & Entrapment Scale (Griffiths et al., 2015)	4. I feel that I am one of life's losers	Scale	1-5	1. Not at all like me; 2. A little bit like me; 3. Quite a bit like me; 4. Moderately like me; 5. Extremely like me
7 items from Mental Pain Scale (Orbach et al., 2003)	1. I feel an emotional turmoil inside me.	Scale	1-5	1 = Does not describe me at all ... 5 = Describes me very well
7 items from Mental Pain Scale (Orbach et al., 2003)	2. I cannot do anything at all.	Scale	1-5	1 = Does not describe me at all ... 5 = Describes me very well
7 items from Mental Pain Scale (Orbach et al., 2003)	3. I am flooded by many feelings.	Scale	1-5	1 = Does not describe me at all ... 5 = Describes me very well
7 items from Mental Pain Scale (Orbach et al., 2003)	4. I feel numb and not alive.	Scale	1-5	1 = Does not describe me at all ... 5 = Describes me very well
7 items from Mental Pain Scale (Orbach et al., 2003)	5. My feelings change all the time.	Scale	1-5	1 = Does not describe me at all ... 5 = Describes me very well
7 items from Mental Pain Scale (Orbach et al., 2003)	6. I feel paralyzed.	Scale	1-5	1 = Does not describe me at all ... 5 = Describes me very well
7 items from Mental Pain Scale (Orbach et al., 2003)	7. There are strong ups and downs in my feelings.	Scale	1-5	1 = Does not describe me at all ... 5 = Describes me very well
Suicidal Ideation	Have you ever thought of taking your life, but not actually attempted to do so?	Scale	1-2	1. Yes; 2. No
Suicide Attempt	Have you ever made an attempt to take your life?	Scale	1-2	1. Yes; 2. No
Self-Esteem Scale, (Rosenberg, 1965)	1. On the whole, I am satisfied with myself	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Esteem Scale, (Rosenberg, 1965)	2. At times I think I am no good at all.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Esteem Scale, (Rosenberg, 1965)	3. I feel that I have a number of good qualities.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Esteem Scale, (Rosenberg, 1965)	4. I am able to do things as well as most other people.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Esteem Scale, (Rosenberg, 1965)	5. I feel I do not have much to be proud of.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Esteem Scale, (Rosenberg, 1965)	6. I certainly feel useless at times.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Esteem Scale, (Rosenberg, 1965)	7. I feel that I'm a person of worth, at least on an equal plane with others.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Esteem Scale, (Rosenberg, 1965)	8. I wish I could have more respect for myself.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree

Self-Esteem Scale, (Rosenberg, 1965)	9. All in all, I am inclined to feel that I am a failure.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Esteem Scale, (Rosenberg, 1965)	10. I take a positive attitude toward myself.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	1. I tend to devalue myself.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	2. I am highly effective at the things I do.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	3. I am very comfortable with myself.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	4. I am almost always able to accomplish what I try for.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	5. I am secure in my sense of self-worth.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	6. It is sometimes unpleasant for me to think about myself.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	7. I have a negative attitude toward myself.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	8. At times, I find it difficult to achieve the things that are important to me.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	9. I feel great about who I am.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	10. I sometimes deal poorly with challenges.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	11. I never doubt my personal worth	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	12. I perform very well at many things.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	13. I sometimes fail to fulfill my goals.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	14. I am very talented.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	15. I do not have enough respect for myself.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
Self-Liking/Self Competence Scale, (Tafarodi & Swann, 1995)	16. I wish I were more skillful in my activities.	Scale	1-4	1. Strongly Agree ; 2. Agree; 3. Disagree; 4. Strongly Disagree
1 item (Failure) from Beck Depression Inventory (BDI-II; Beck, Steer & Brown, 1996)	Pick one statement that best describes the way you have been feeling during the past two weeks, including today.	Scale	1-4	1. I do not feel like a failure.; 2. I have failed more than I should have.; 3. As I look back, I see a lot of failures.; 4. I feel I am a total failure as a person.
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	1. There is a special person who is around when I am in need	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	2. There is a special person with whom I can share my joys and sorrows	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree

The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	3. My family really tries to help me	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	4. I get the emotional help and support I need from my family	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	5. I have a special person who is a real source of comfort to me	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	6. My friends really try to help me	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	7. I can count on my friends when things go wrong	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	8. I can talk about my problems with my family	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	9. I have friends with whom I can share my joys and sorrows	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	10. There is a special person in my life who cares about my feelings	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	11. My family is willing to help me make decisions	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)	12. I can talk about my problems with my friends	Scale	1-7	1. Very Strongly Disagree; 2. Strongly Disagree; 3. Mildly Disagree; 4. Neutral; 5. Mildly Agree; 6. Strongly Agree; 7. Very Strongly Agree
The De Jong Gierveld 6-Item Scale Loneliness Scale (Gierveld & Van Tilburg, 2006)	1. I experience a general sense of emptiness	Scale	1-5	1. Yes!; 2. Yes; 3. More or less; 4. No; 5. No!
The De Jong Gierveld 6-Item Scale Loneliness Scale (Gierveld & Van Tilburg, 2006)	2. I miss having people around me	Scale	1-5	1. Yes!; 2. Yes; 3. More or less; 4. No; 5. No!
The De Jong Gierveld 6-Item Scale Loneliness Scale (Gierveld & Van Tilburg, 2006)	3. I often feel rejected	Scale	1-5	1. Yes!; 2. Yes; 3. More or less; 4. No; 5. No!
The De Jong Gierveld 6-Item Scale Loneliness Scale (Gierveld & Van Tilburg, 2006)	4. There are plenty of people I can rely on when I have problems	Scale	1-5	1. Yes!; 2. Yes; 3. More or less; 4. No; 5. No!
The De Jong Gierveld 6-Item Scale Loneliness Scale (Gierveld & Van Tilburg, 2006)	5. There are many people I can trust completely	Scale	1-5	1. Yes!; 2. Yes; 3. More or less; 4. No; 5. No!

The De Jong Gierveld 6-Item Scale Loneliness Scale (Gierveld & Van Tilburg, 2006)	6. There are enough people I feel close to	Scale	1-5	1. Yes!; 2. Yes; 3. More or less; 4. No; 5. No!
General Mattering Scale (Marcus, 1991)	1. How important are you to others?	Scale	1-4	1. Not at all; 2. A little; 3. Somewhat; 4. Very much
General Mattering Scale (Marcus, 1991)	2. How much do others pay attention to you?	Scale	1-4	1. Not at all; 2. A little; 3. Somewhat; 4. Very much
General Mattering Scale (Marcus, 1991)	3. How much would you be missed if you went away?	Scale	1-4	1. Not at all; 2. A little; 3. Somewhat; 4. Very much
General Mattering Scale (Marcus, 1991)	4. How interested are others in what you have to say?	Scale	1-4	1. Not at all; 2. A little; 3. Somewhat; 4. Very much
General Mattering Scale (Marcus, 1991)	5. How much do other people depend upon you?	Scale	1-4	1. Not at all; 2. A little; 3. Somewhat; 4. Very much

Appendix 4.4 Demographic and clinical characteristics by suicidal history (Study 2, Chapter 4)

(N (%) or M (SD))

Psychosocial Factor	Total 2685 (100%)	No Suicidal History 280 (10%)	Suicidal Thoughts 1634 (61%)	Suicide Attempts 771 (29%)
	Sociodemographics			
Age	18-30: 1681 (61%) 31-50: 845 (30%) 51+: 237 (8%)	18-30: 169 (54%) 31-50: 94 (30%) 51+: 49 (16%)	18-30: 1033 (62%) 31-50: 513 (31%) 51+: 124 (7%)	18-30: 479 (61%) 31-50: 238 (30%) 51+: 64 (8%)
Gender				
Trans / Gender Queer / Prefer Not to Say	96 (3%)	2 (1%)	32 (2%)	62 (8%)
Male (ref)	2667 (97%)	310 (99%)	1638 (98%)	719 (92%)
Sexuality				
Gay / Bisexual / Not Sure	646 (23%)	33 (11%)	346 (21%)	267 (34%)
Straight (ref)	2117 (77%)	279 (89%)	1324 (79%)	514 (66%)
Relationship Status				
Single / Divorced / Separated / Widowed / Other	1697 (61%)	138 (44%)	1043 (62%)	516 (66%)
Married / In a relationship (ref)	1066 (39%)	174 (56%)	627 (38%)	265 (34%)
Ethnicity				
Black / Asian / Arab / Mixed	527 (19%)	54 (17%)	314 (19%)	159 (20%)
White (ref)	2236 (81%)	258 (83%)	1356 (81%)	622 (80%)

Employment				
Unemployed	472 (17%)	17 (5%)	270 (16%)	185 (24%)
Student / Stay at home parent / Retired	670 (24%)	80 (26%)	412 (25%)	178 (23%)
In employment (ref)	1621 (59%)	215 (69%)	988 (59%)	418 (54%)
Financial				
Doing alright / Just about getting by	1628 (59%)	148 (47%)	1016 (61%)	462 (59%)
Finding it quite difficult / Finding it very difficult	381 (14%)	18 (6%)	190 (11%)	173 (22%)
Living comfortably (ref)	754 (27%)	146 (47%)	464 (28%)	144 (18%)
Mental Health and Suicidal Behaviours				
Mental Health Diagnosis				
Yes	1307 (47%)	52 (16%)	709 (42%)	547 (70%)
No (ref)	1456 (53%)	262 (84%)	961 (58%)	234 (30%)
Covid-19				
Impact on life (‘0’ no impact / ’10’ severe impact)	5.47 (2.85)	5.50 (2.80)	5.58 (2.78)	5.23 (3.00)
Financial Impact (‘0’ no impact / ’10’ severe impact)	3.09 (3.14)	2.83 (3.02)	2.98 (3.05)	3.45 (3.34)
Impact on wellbeing (‘0’ no impact / ’10’ severe impact)	5.33 (3.10)	4.68 (2.98)	5.45 (3.020	5.36 (3.28)

Appendix 4.5 Psychosocial factors by suicidal history (Study 2, Chapter 4)

(N (%) or M (SD))

Psychosocial Factor	Total	No Suicidal History	Suicidal Thoughts	Suicide Attempts
Psychological Variables				
Emotional and Psychological Pain:				
Depression *(from PHQ)*	30.38 (21.21)	11.96 (13.95)	29.57 (20.08)	39.49 (20.8)
Conformity to Masculine Norms *(Emotions and Self Reliance)*	4.18 (1.07)	3.83 (1.04)	4.19 (1.08)	4.29 (1.09)
Attitudes to Emotions	62.51 (15.12)	54.17 (14.48)	62.17 (14.6)	66.58 (15.01)
Mental Pain *(Flooding and Freezing)*	19.94 (7.54)	12.83 (6.17)	19.81 (7.12)	23.04 (6.92)
Entrapment	12.77 (5.18)	7.52 (3.84)	12.8 (4.92)	14.82 (4.7)
Defeat	11.86 (5.62)	6.45 (3.63)	11.78 (5.39)	14.18 (5.23)
Feelings about Self:				
Failure *(from BDI-II)*	2.55 (1.04)	1.65 (0.83)	2.53 (0.99)	2.95 (0.98)
Self-Esteem Scale	27.09 (6.97)	19.98 (6.15)	27.15 (6.47)	29.81 (6.3)
Self-Liking/Self-Competence	46.56 (9.2)	37.43 (8.73)	46.71 (8.44)	49.88 (8.5)
Connections with Others:				
Perceived Social Support	4.22 (2.19)	5.24 (1.85)	4.19 (2.17)	3.86 (2.23)
General Mattering Scale	12.37 (3.93)	15.12 (3.71)	12.42 (3.72)	11.17 (3.9)
Loneliness Scale	4.48 (1.71)	2.76 (2)	4.59 (1.59)	4.94 (1.37)

Appendix 4.6 Collinearity (Study 2, Chapter 4)

Collinearity for Model 1 - men who are not suicidal (reference: not suicidal) vs men with thoughts of suicide (ideation); Model 2 - men who are not suicidal (reference: not suicidal) vs men who have attempted suicide (attempt),

Correlation	Term	VIF	VIF_CI_low	VIF_CI_high	SE_factor	Tolerance	Tolerance_CI_low	Tolerance_CI_high
Low	Mental Health Diagnosis	4.776	4.474	5.104	2.185	0.209	0.196	0.223
Low	Attitudes towards Emotional Expression	4.381	4.107	4.679	2.093	0.228	0.214	0.243
Low	Perceived Social Support	4.908	4.597	5.246	2.215	0.204	0.191	0.218
Moderate	Sexuality	5.174	4.844	5.532	2.275	0.193	0.181	0.206
Moderate	Failure*	9.436	8.804	10.12	3.072	0.106	0.099	0.114
Moderate	General Mattering	6.183	5.782	6.618	2.487	0.162	0.151	0.173
Moderate	Loneliness	5.04	4.719	5.388	2.245	0.198	0.186	0.212
High	Employment	20.404	18.994	21.924	4.517	0.049	0.046	0.053
High	Financial	16.651	15.507	17.884	4.081	0.06	0.056	0.064
High	Mental Pain*	12.042	11.225	12.925	3.47	0.083	0.077	0.089
High	Entrapment	17.25	16.064	18.53	4.153	0.058	0.054	0.062
High	Defeat	22.799	21.219	24.502	4.775	0.044	0.041	0.047

High	Self-Esteem	15.924	14.832	17.103	3.991	0.063	0.058	0.067
High	Self-Liking/Self Competence	12.404	11.561	13.314	3.522	0.081	0.075	0.086
High	Depression*	13.924	12.973	14.949	3.731	0.072	0.067	0.077

Collinearity for Model 3 - men with thoughts of suicide (reference: ideation) vs men who have attempted suicide (attempt)

Correlation	Term	VIF	VIF_CI_low	VIF_CI_high	SE_factor	Tolerance	Tolerance_CI_low	Tolerance_CI_high
Low	Sexuality	1.052	1.024	1.113	1.025	0.951	0.898	0.977
Low	Employment	1.156	1.115	1.213	1.075	0.865	0.825	0.897
Low	Financial	1.278	1.226	1.342	1.13	0.782	0.745	0.815
Low	Mental Health Diagnosis	1.094	1.059	1.15	1.046	0.914	0.87	0.944
Low	Failure*	2.26	2.137	2.396	1.503	0.442	0.417	0.468
Low	Attitudes towards Emotional Expression	1.502	1.433	1.581	1.225	0.666	0.632	0.698
Low	Mental Pain*	2.792	2.631	2.969	1.671	0.358	0.337	0.38
Low	Entrapment	3.7	3.474	3.945	1.923	0.27	0.253	0.288
Low	Defeat	3.945	3.702	4.209	1.986	0.254	0.238	0.27
Low	Self-Esteem	4.374	4.101	4.671	2.091	0.229	0.214	0.244
Low	Self-Liking/Self Competence	3.798	3.565	4.051	1.949	0.263	0.247	0.28
Low	Perceived Social Support	1.392	1.332	1.464	1.18	0.718	0.683	0.751
Low	General Mattering	1.883	1.787	1.991	1.372	0.531	0.502	0.56
Low	Loneliness	2.165	2.049	2.294	1.472	0.462	0.436	0.488
Low	Depression*	2.336	2.207	2.478	1.528	0.428	0.404	0.453

Appendix 4.7 Variables included in the Multivariate Analysis (Study 2, Chapter 4)

Psychological Variables:

The following psychological variables were included in the multivariate analysis:

> Domain 1: Emotional and Psychological Pain: Depressive Symptoms (from PHQ), Attitudes to Emotions, Mental Pain (Flooding and Freezing), Entrapment, and Defeat,
>
> Domain 2: Feelings about Self: Failure, Self-Esteem Scale, Self-Liking/Self-Competence,
>
> Domain 3 Connections with Others: Perceived Social Support, General Mattering Scale, Loneliness Scale.

Sociodemographic Variables:

The reference categories (that serve as a point of comparison for the other categories) of the nominal variables included were: Sexuality (reference = "straight", other categories = "other"), mental health diagnosis (reference = "No", other categories = "Yes"), Employment (reference = "In employment", other categories = "unemployed", "student or retired or homemaker"), Financial (reference = "Living comfortably", other categories = "Doing alright or just about getting by" and "Finding it quite difficult or very difficult"). This means that by choosing "No" as the reference category for mental health diagnosis, for example, the model estimated the effect of the independent variables on the odds or probability of having a "Yes" mental health diagnosis compared to not having a mental health diagnosis.

Appendix 4.8 R Data Analysis Script, Sample (Study 2, Chapter 4)

```
# Details ----------------------------------------------------------------

# In this script we clean and transform the main variables,
# and filter by certain characteristics to generate the database for the analysis.

# PKG ----------------------------------------------------------------------

# Import packages
library(readxl) # read excels
library(dplyr) # data manipulation
library(writexl) # export excels

# IMPORT DATA ------------------------------------------------------------

df_raw <- readxl::read_xlsx('data/OriginalData/8. LOGISITICS DATA FILE (3134).xlsx')

df_raw <- df_raw[-c(1:3),] # remove rows

glimpse(df_raw)



# We clean and transform the variables
df  <- df_raw %>%

  mutate(
    # convert to numeric every variable excepts these ones
```

```
across( -c( dem_urn, dem_consent,dem_location_clean ), as.numeric ),

# change suicide status labels
'suicide_status' = case_when(

  si == '2' & sa == '2' ~ 'NS',
  si == '1' & sa == '2' ~ 'SI',
  sa == '1' ~ 'SA',

  TRUE ~ NA_character_
),
# move to NA values below 18
'dem_age_clean' = ifelse( dem_age_clean < 18, NA, dem_age_clean ),

# cut and convert age to categorical variable (factor)
'dem_age_label' = cut(dem_age_clean, breaks = c(-Inf,30,50,Inf),
                      labels = c('18-30','31-50','+51')),
# change gender labels
'dem_gender' = factor(dem_gender, 1:4, c('Man',rep('Other',3))),
# change ethnicity labels
'dem_ethnicity' = factor(dem_ethnicity, 1:6, c('White',rep('Other',5))),
# change sexuality labels
'dem_sexuality' = factor(dem_sexuality, 1:5, c('Straight',rep('Other',4))),
# change relationship labels
'dem_relationship' = factor( case_when(

  dem_relationship %in% c(1,3,4,6) ~ 'Single or divorced or separated or widowed',
  dem_relationship %in% c(7) ~ 'Other',
```

```
  dem_relationship %in% c(2,5) ~ 'Married or in a relationship',
  TRUE ~ NA_character_
), c('Married or in a relationship', 'Single or divorced or separated or widowed',
     'Other') ),

# change employment labels
'dem_employment' = factor( case_when(
  dem_employment %in% c(3,4) ~ 'Unemployed',
  dem_employment %in% c(5,6,7) ~ 'Student / Stay at home parent / Retired',
  dem_employment %in% c(1,2) ~ 'In employment',
  TRUE ~ NA_character_
), c('In employment', 'Student / Stay at home parent / Retired',
     'Unemployed') ),
#  change financial labels
'dem_financial' = factor( case_when(

  dem_financial %in% c(2,3) ~ 'Doing alright / Just about getting by',
  dem_financial %in% c(4,5) ~ 'Finding it quite difficult / Finding it very difficult',
  dem_financial %in% c(1) ~ 'Living comfortably',
  TRUE ~ NA_character_
), c('Living comfortably', 'Finding it quite difficult / Finding it very difficult',
     'Doing alright / Just about getting by')),
#  change mental health diagnosis labels
'dem_mh_diagnosis' = factor(dem_mh_diagnosis, 1:2, c('Yes','No')),

# we substract 1 to all the variables from emot_depress_1 to emot_depress_9,
# because the range is 0 to 3 but in the data is 1 to 4
across( all_of( paste0('emot_depress_',1:9) ), ~ .x-1 )
```

```
  ) %>%
  # remove missings values
  filter( !is.na( suicide_status ) ) %>%  # 46 missings values
  # keep only people equal or above 18
  filter( dem_age_clean >= 18 ) %>% # keep only people who are >= 18 years
  # rename these variables
  rename( 'emot_masc_control_1' = emot_masc_contol_1,
          'emot_masc_control_2' = emot_masc_contol_2,
          'emot_masc_control_3' = emot_masc_contol_3)


# Export ------------------------------------------------------------------


# Export clean data
writexl::write_xlsx( df, 'data/df_logistic_clean.xlsx' )
```

Appendix 5.1 Participant Demographics

	Total	Ideation	Attempt
Gender			
Man	95%	98%	91%
Trans Man	2%	1%	4%
Genderqueer	1%	0%	2%
Prefer not to say	2%	1%	3%
Age			
18-30	72%	74%	71%
31-50	23%	22%	26%
51+	4%	5%	3%
Ethnicity			
Arab / Arab British	1%	1%	0%
Asian / Asian British	6%	6%	6%
Black / African / Caribbean / Black British	2%	2%	2%
Mixed / Multiple ethnicities	7%	6%	10%
Other	6%	6%	6%
White	78%	80%	75%
Relationship Status			
Single	71%	73%	68%
In a relationship	17%	15%	20%
Married	8%	9%	7%
Divorced	2%	1%	3%
Other	1%	1%	2%
Separated	1%	2%	0%
Widowed	0%	0%	0%
Children			
No	88%	88%	88%
Yes	11%	11%	12%
Sexuality			
Straight (Heterosexual)	72%	74%	67%
Bisexual	13%	12%	14%
Gay (Homosexual)	6%	5%	7%
Not sure	5%	6%	4%
Other	4%	2%	7%
Education			
Completed school to age 16	19%	16%	24%

Completed school to age 18	22%	22%	22%
I was not able to complete school	4%	4%	5%
Other vocational qualification	8%	7%	9%
Postgraduate Degree	12%	15%	8%
Undergraduate Degree	34%	35%	32%
Employment			
Employed full time	38%	39%	37%
Employed part time	11%	12%	11%
Retired	1%	1%	0%
Stay at home parent	1%	0%	1%
Student	26%	27%	24%
Unemployed and seeking work	15%	16%	14%
Unemployed due to disability/incapacity	8%	5%	13%
Financial			
Doing alright	35%	37%	32%
Just about getting by	28%	28%	29%
Living comfortably	17%	20%	12%
Finding it quite difficult	13%	11%	15%
Finding it very difficult	7%	5%	11%
Mental Health Diagnosis			
Yes	47%	36%	63%
No	47%	59%	29%
Prefer not to say	6%	5%	8%
	Total	**Ideation**	**Attempt**
COVID Overall Impact	*Mean (SD)*	*Mean (SD)*	*Mean (SD)*
'0 - no affect at all' to '10 - Severely affects my life'	6 (4.99)	6 (4.92)	5 (5.04)
COVID Impact on Wellbeing			
'0 - no affect at all' to '10 - Severely affects my life'	5 (5.01)	5 (5.02)	4 (4.99)
COVID Impact on Financial			
'0 - no affect at all' to '10 - Severely affects my life'	1 (3.46)	1 (3.02)	2 (3.98)

Appendix 5.2 Codebook, Sample (Study 3, Chapter 5)

Title	Candidate Theme	Sub-Theme	Basic Code
PHYSICAL OPPORTUNITY	Physical Opportunity (Prohibitive Costs)	Inaccessible (Prohibitive Costs)	**A therapy would be very expensive. Unfortunately the vast majority of people cannot allow it.**
MOTIVATION	Motivation (Negative Past Experiences)	Futile (Negative Past Experiences)	**Tried before. Was no help whatsoever and the waiting period was ridiculous**
PHYSICAL OPPORTUNITY	Physical Opportunity (Prohibitive Costs)	Inaccessible (Prohibitive Costs)	**I can't afford professional support.**
CAPABILITY	Poverty of Capability (Emotions)	Poverty of (Self Esteem)	**Feeling like I'm unwanted there, too much trouble for the therapist,** shame
MOTIVATION	Motivation (Mistrust of Professionals)	Mistrust of Professionals (Trust)	**Trust in professionals. Gaslighting by professionals to me and my identity for my feelings.** Cost and time
PHYSICAL OPPORTUNITY	Physical Opportunity (Prohibitive Costs)	Inaccessible (Prohibitive Costs)	Trust in professionals. Gaslighting by professionals to me and my identity for my feelings. **Cost** and time
SOCIAL OPPORTUNITY	Social Opportunity (Seeking Help as Shameful)	Harm (Shameful Transgression)	**"Pride"** 🙄
MOTIVATION	Motivation (Negative Past Experiences)	Futile (Negative Past Experiences)	When im at the point of attempt or close to i dont want to be stopped so why would i contact anybody? **Also experience of mentalhealth support very poor**
MOTIVATION	Motivation (Apathy & Desire to Die)	Futile (Desire to Die)	**When im at the point of attempt or close to i dont want to be stopped so why would i contact anybody?** Also experience of mentalhealth support very poor
PHYSICAL OPPORTUNITY	Physical Opportunity (Prohibitive Costs)	Inaccessible (Prohibitive Costs)	**money**, low quality services
MOTIVATION	Motivation (Negative Past Experiences)	Futile (Negative Past Experiences)	**I wasnt helped anytime I asked before**

MOTIVATION	Motivation (Mistrust of Professionals)	Mistrust of Professionals (Care)	**Even as a mental health professional, i feel.it is a lottery if you get a MH professional who cares or is unhelpful.**
MOTIVATION	Motivation (Negative Past Experiences)	Futile (Negative Past Experiences)	I would if I could afford it or **NHS** weren't so **useless**
PHYSICAL OPPORTUNITY	Physical Opportunity (Prohibitive Costs)	Inaccessible (Prohibitive Costs)	**I would if I could afford it** or NHS weren't so useless
MOTIVATION	Motivation (Negative Past Experiences)	Futile (Negative Past Experiences)	**I have sought professional help in the past. Talking over the same things would not help me.**
PHYSICAL OPPORTUNITY	Physical Opportunity (Scarcity of Services)	Inaccessible (Scarcity of Services - Waiting Times)	**Waiting times**
MOTIVATION	Motivation (Negative Past Experiences)	Futile (Negative Past Experiences)	**I've tried several things that have had no effect. Been to GP several times. Tried several different medications. Been to group CBT sessions. Had one on one CBT sessions. Nothing has ever had any positive effect. Feels like there is no point in trying anything else and I am destined to live like this forever.**

Appendix 5.3 *Most endorsed sub-themes segmented by recency of suicidal behaviours, age; location (Study 3, Chapter 5)*

Recency of Suicidal Behaviours	**# 1 sub-theme**	**# 2 sub-theme**
Attempt this Week	No Motivation - Negative Past Experiences	No Motivation - Sceptical Beliefs about the Utility of Professional Support
Attempt this Year	No Opportunity - Prohibitive Costs	No Motivation - Negative Past Experiences
Attempt Longer Ago; Ideation this Week	No Motivation - Negative Past Experiences	No Opportunity - Prohibitive Costs
Attempt Longer Ago; Ideation this Year	No Opportunity - Prohibitive Costs	No Motivation - Negative Past Experiences
Ideation this Week	No Opportunity - Prohibitive Costs	No Motivation - Negative Past Experiences
Ideation this Year	No Opportunity - Prohibitive Costs	No Motivation - Sceptical Beliefs about the Utility of Professional Support
Age	**# 1 sub-theme**	**# 2 sub-theme**
18-30	No Opportunity - Prohibitive Costs	No Motivation - Negative Past Experiences
31 to 50	No Motivation - Negative Past Experiences	No Opportunity - Prohibitive Costs
50+	No Motivation - Negative Past Experiences	No Motivation – Loss of Autonomy, Agency, and Control / No Opportunity - Prohibitive Costs
Location	**# 1 sub-theme**	**# 2 sub-theme**
Upper-Income	No Opportunity - Prohibitive Costs	No Motivation - Negative Past Experiences
Upper-Middle-Income	No Opportunity - Prohibitive Costs	No Motivation - Negative Past Experiences
Lower-Middle-Income	No Opportunity - Prohibitive Costs	No Motivation - Sceptical Beliefs about the Utility of Professional Support / No Opportunity - Harm to Social Value and Relationships

Appendix 6.1 Codebook, Sample (Study 4, Chapter 6)

Descriptive Theme	Source	Index	Code	Potential Questions
Male Friendship	Grey Literature	9_USA	Beyond the age of 30, men have fewer supportive peer relationships than women, and are dependent on a female partner for emotional support. (p.4. Men and Suicide, Samaritans, 2012).	Exploring who men who are suicidal talk to about their emotional problems: what helps, what doesn't, what could help?
Male Friendship	Grey Literature	9_USA	Men do have male friendships that are important to them, although they do not talk to these friends about emotional issues on a regular basis. While women have nurturing relationships, men tend to prefer companionship through doing activities together. (P.13, Men and Suicide, Samaritans, 2012).	Exploring who men who are suicidal talk to about their emotional problems: what helps, what doesn't, what could help?
Male Friendship	Grey Literature	9_USA	At crisis points, such as a partner's miscarriage, men may speak to particular friends. They choose who they speak to carefully. They look for someone who will listen to what they say without asking questions or judging, someone who knows the background to their problems, and someone they trust not to tell anyone else. They also want to talk 'spontaneously', as planning to talk about their problems feels emasculating. But more commonly, the 'healthy' ways men cope are using music or exercise to manage stress or worry. (P.13, Men and Suicide, Samaritans, 2012).	Exploring who men who are suicidal talk to about their emotional problems: what helps, what doesn't, what could help?
Male Friendship	Grey Literature	9_USA	Relationships between men tend to be concerned more with 'doing' and 'being alongside' than the self-revelation and nurturance of women's friendships. Men's friendships should not be judged as without value because they do not follow the same 'script' for intimacy as women's. (p.14, Samaritans, 2012)	Understanding what meaningful connection with significant others means for men who are suicidal OR Understanding how men who are suicidal build intimacy and connection with significant others

Male Friendship	Grey Literature	9_USA	Joiner (2011) has presented considerable evidence about the loneliness of men. Even where men have a good number of social contacts, the quality of these relationships might be such that these men could still be considered lonely. He notes that many men do not realise they are lonely, preoccupied as they are with work, but in difficult times, for example when a marriage fails, they might be suddenly struck by their lack of meaningful social support. (p.43, Samaritans, 2012)	Investigating loneliness and isolation for men who are suicidal OR Understanding what meaningful connection with significant others means for men who are suicidal OR Investigating the best ways to support men to create and/or sustain meaningful relationships with others OR Investigating challenges in creating and/or sustaining meaningful connections with significant others OR Understanding how men who are suicidal build intimacy and connection with significant others
Male Friendship	Grey Literature	9_USA	Yet, there is also evidence that, while men may fear male friends finding out about their mental distress (O'Brien et al., 2005), these friendships are also valued, and in some settings (Singleton, 2003) and at certain times, may be a significant source of emotional support. In the STTT study, few of the men interviewed described close male friends to whom they spoke on a regular basis about emotional issues. More men did, however, describe friendships that were emotionally significant, even if they did not involve talk, and crisis times, such as a partner's miscarriage, when they did speak to particular male friends. (p.101, Samaritans, 2012)	Investigating loneliness and isolation for men who are suicidal OR Understanding what meaningful connection with significant others means for men who are suicidal OR Investigating the best ways to support men to create and/or sustain meaningful relationships with others OR Investigating challenges in creating and/or sustaining meaningful connections with significant others OR Understanding how men who are suicidal build intimacy and connection with significant others
Male Friendship	Grey Literature	9_USA	We need to be cautious of underestimating the ways in which men do intimacy and offer support both to other men and to women. It has come to be taken as read that men's friendships, for example, are of a different order from women's: less based on self-revelation and nurturance, and more concerned with 'doing' and 'being alongside' (O'Connor, 1992; Rubin, 1986; Nardi, 1992). It is easy for this difference to be read according to feminised scripts of intimacy, and for men's relationships then to be found wanting (Cancian, 1987). (p.101, Samaritans, 2012)	Understanding what meaningful connection with significant others means for men who are suicidal OR Understanding how men who are suicidal build intimacy and connection with significant others

Appendix 6.2 Round 1 Questions (Study 4, Chapter 6)

Exploring Structural Factors

These questions explore male suicide risk and recovery factors related to structural factors such as political, social and economic conditions. Which questions do you think are most important for us to study?

Should NOT be included / Low importance / I don't know / It depends / Important / Essential

1. Financial pressures/debt and male suicide risk
2. Work stress and male suicide risk i.e., work pressures, self-employment, insecure work conditions, workplace bullying, not doing work that makes use of skills and abilities
3. The combined impact of multiple structural factors and male suicide risk i.e., being unemployed, having a disability and living in insecure housing
4. Unemployment and male suicide risk
5. Insecure housing/homelessness and male suicide risk
6. Poverty and male suicide risk
7. Homophobia/biphobia and male suicide risk
8. Exploring the best ways that workplaces can support men who are suicidal
9. Legal issues and male suicide risk
10. Social media and male suicide risk
11. Transphobia and male suicide risk
12. Racism and male suicide risk
13. Disability discrimination and male suicide risk
14. Impact of current and/or historical policy changes and male suicide risk i.e., government spending cuts and male suicide risk
15. Misandry (prejudice against men such as discrimination against men, negative messages about men) and male suicide risk
16. Understanding the importance of work as providing meaning, fulfilment and identity to men who are suicidal

    Is there anything missing in this area that you think is important?

Exploring Cultural Factors

These questions explore risk and recovery factors relating to social/cultural beliefs and expectations for men and male behaviour. Which questions do you think are most important for us to study?

Should NOT be included / Low importance / I don't know / It depends / Important / Essential

1. Exploring differences in how male and female distress is understood and responded to by people
2. Exploring what 'being a man' means to men who are suicidal
3. Exploring how men who are suicidal perceive society as viewing men and how these views have changed over time
4. Exploring ideas of masculinity that men who are suicidal find helpful (i.e., how can masculinity and male strengths be used to protect men from suicide? How would men like to see masculinity celebrated and uplifted in our cultures?)
5. Exploring how men who are suicidal develop and form their ideas of masculinity (who are the main influences on ideas and behaviours i.e., family, friends, media, education, religion etc)
6. Exploring the presence or absence of male role models in the lives of men who are suicidal

    Is there anything missing in this area that you think is important?

Exploring Relationships

These questions explore risk and recovery factors that relate to men's relationships with other people. Which questions do you think are most important for us to study?

Should NOT be included / Low importance / I don't know / It depends / Important / Essential

Significant Others. These questions explore the relationship that men who are suicidal have with significant others including, family, friends, children, and romantic partners.

1. Investigating loneliness and isolation for men who are suicidal
2. Understanding what meaningful connection with significant others means for men who are suicidal
3. Investigating the best ways to support men to create and/or sustain meaningful relationships with others
4. Investigating men as victims of and/or perpetuators of domestic abuse (physical, sexual, emotional, and/ or psychological) and male suicide risk
5. Investigating how connections with significant others can protect men who are suicidal from suicide
6. Investigating challenges in creating and/or sustaining meaningful connections with significant others
7. Understanding how men who are suicidal build intimacy and connection with significant others

Romantic Relationships

8. Investigating romantic breakups and male suicide risk
9. Investigating how men who are suicidal deal with conflict in their relationships with significant others
10. Investigating the absence of a romantic partner and male suicide risk

Being a Father

11. Investigating parental alienation and male suicide risk
12. Investigating parenting challenges and male suicide risk

Is there anything missing in this area that you think is important?

Exploring the Psychology of Men

These questions explore suicide risk and recovery factors that relate to things happening inside the psychology of individual men i.e., the emotions and thoughts that men experience that may increase suicide risk. Our emotions and thoughts are influenced by many things including biological and external factors - such as work, family, and other cultural and structural factors already discussed. In this section, we are interested in what is happening inside the psychology of men due to all these different factors. Which questions do you think are most important for us to study?

Should NOT be included / Low importance / I don't know / It depends / Important / Essential

1. Exploring the main sources of stress and emotional pain for men who are suicidal
2. Exploring the best ways to support men who are suicidal to repair harmful thoughts and feelings about themselves
3. Exploring how men who are suicidal understand, manage and express their emotions and emotional pain
4. Exploring who men who are suicidal talk to about their emotional problems: what helps, what doesn't, what could help?
5. Exploring the experiences of men who are suicidal of seeking help: what helps, what doesn't, what could help?
6. Understanding men's suicidal thoughts and feelings (i.e., how do thoughts of suicide develop, what are the contents of men's suicidal thoughts, what triggers thoughts, how long do they last, are thoughts heightened at certain times of day/night, how do thoughts of suicide impact other areas of men's lives?)
7. Exploring self-esteem (i.e., positive and/or negative thoughts and feelings about yourself) as a male suicide risk and recovery factor
8. Exploring the most effective ways of supporting men who are suicidal to manage their emotions and emotional pain
9. Exploring having a sense of purpose and meaning as male suicide risk and recovery factor

10. Exploring how men manage thoughts of suicide and what prevents men from acting on them
11. Investigating the relationship between having a mental health condition (i.e., depression, social anxiety, bipolar, anxiety) and male suicide risk
12. Exploring what triggers a shift from thinking about suicide to planning a suicide
13. Exploring the past-thinking and future-thinking of men who are suicidal (e.g., constantly thinking about what has gone wrong in the past/feeling worried about the future)
14. Exploring the thought patterns and emotional states of men when planning suicidal action
15. Exploring what language and messages are best to engage men who are suicidal around mental health issues
16. Exploring the coping strategies men who are suicidal use (i.e., food, alcohol, drugs, medication, gambling, gaming, the internet etc.)
17. Exploring the attitude of men who are suicidal towards seeking help
18. Exploring how men's mental health and suicide are represented in society and how these ideas impact men who are suicidal
19. Exploring control and agency (i.e., having the ability and power to do the things you want and to make your own choices) as male suicide risk and recovery factors
20. Exploring surviving sexual abuse/assault and male suicide risk
21. Exploring self-reliance (i.e., relying on yourself rather than other people) as a male suicide risk and recovery factor
22. Exploring how men who are suicidal think and feel about their body and physical appearance
23. Exploring sexual minority men (i.e., gay/bi/pansexual men) and male suicide risk
24. Exploring the relationship men who are suicidal have with food and diet
25. Exploring what suicide means to men who are suicidal
26. Exploring male sexuality (i.e., feeling sexually desirable, frequency of sex, sexual satisfaction, porn/masturbation, virginity, attraction to minors etc) and male suicide risk
27. Exploring false accusations of sexual assault (e.g., reports to police or authorities, rumours/gossip) and male suicide risk

Is there anything missing in this area that you think is important?

Exploring Experiences in Early Life

These questions explore experiences in early life - up to the age of 18 - that may increase suicide risk for some men. Which questions do you think are most important for us to study?Exploring the best ways to support young men who are suicidal

Should NOT be included / Low importance / I don't know / It depends / Important / Essential

1. Exploring how young men seek help (i.e., talking to teachers, peers, medical professionals, chat rooms) and cope with their problems
2. Exploring how mental health problems - including suicidal thoughts, feelings and attempts - develop in young men
3. Exploring the long-term impact of early life challenges for men who are suicidal
4. Experiencing or witnessing physical/emotional neglect
5. Experiencing or witnessing psychological/emotional abuse
6. Family controlling behaviours, pressure and/or expectations
7. Experiencing or witnessing physical abuse
8. Death by suicide of a significant other
9. Experiencing or witnessing sexual abuse
10. Mental health problems in the caregiving home
11. Sibling Abuse
12. Growing up in care
13. Growing up as a minority (i.e., racial, sexual, trans, religious)
14. Moving multiple times in childhood
15. Investigating the impact of early life bullying and male suicide risk
16. Caregiver absence, abandonment or estrangement

17. Caregiver(s) struggling with personal problems (e.g., financial, legal, emotional, health)
18. Caregiver relationship conflict - including separation and/or divorce
19. Addiction problems in the caregiving home
20. Death of a significant other
21. Growing up with a disability / physical health challenges
22. Growing up with neuro-divergency (such as ADHD or Autism)
23. Growing up in poverty

Is there anything missing in this area that you think is important?

Exploring Support and Recovery
These questions explore experiences relating to accessing support and learning to manage suicidal thoughts, feelings and behaviours. Which questions do you think are most important for us to study?

Should NOT be included / Low importance / I don't know / It depends / Important / Essential

1. Exploring effective interventions for men who cannot afford / access therapy
2. Exploring the experience of men who are suicidal of seeking professional support: what helps, what doesn't, what could help?
3. Exploring different intervention types (i.e. talk therapy, medication): what helps, what doesn't, what could help?
4. Exploring the most effective long-term support for men who are suicidal: what helps, what doesn't, what could help?
5. Exploring the experience of men who are suicidal of seeking support from significant others: what helps, what doesn't, what could help?
6. Understanding what training healthcare professionals need to better identify and engage at-risk men
7. Understanding how men cope after a suicide attempt: what helps, what doesn't, what could help?
8. Exploring what recovery means for men who have attempted suicide and men's reasons for living
9. Exploring men's relationship with health-care professionals: what helps, what doesn't, what could help?
10. Exploring the experiences of significant others when supporting men who are suicidal: what helps, what doesn't, what could help?
11. Exploring the most effective support in the six months following a suicide attempt: what helps, what doesn't, what could help?
12. Exploring how academic researchers and health care professionals can work together to incorporate research findings into services
13. Exploring what professional support men who are suicidal want to receive (i.e., What areas of life do men want help with? What skills do men want support to build?)
14. Exploring differences in how men and women present suicide risk and the best gender-sensitive screening tools for health services professionals
15. Exploring how to create communities that support men who are suicidal better
16. Understanding how different services can work together better (i.e., how can the criminal justice system work with mental health care?)
17. Exploring how to best measure the outcome of interventions, i.e., increased self-esteem and reduced suicide risk
18. Exploring the experiences of men who are suicidal of accessing support in their community: what helps, what doesn't, what could help?
19. Exploring effective training for community members to support men who are suicidal (80%)
20. Exploring the experiences of health service professionals (e.g., doctors, therapists, psychologists, psychiatrists etc.) of working with men who are suicidal
21. Exploring emergency admission and discharge: what helps, what doesn't, what could help?
22. Exploring effective community mental health role models for men who are suicidal
23. Exploring effective community members who can spot and engage at-risk men
24. Exploring the experiences of community members who support men who are suicidal: what helps, what doesn't, what could help?

Is there anything missing in this area that you think is important?

Exploring Potentially Vulnerable Groups
The research questions suggested in this survey apply to all men irrespective of their background. However, certain groups of men have been identified as at particular risk of suicide. Of these populations which do you consider to be of high priority?

Should NOT be included / Low importance / I don't know / It depends / Important / Essential

1. Male survivors of abuse
2. Middle-aged men
3. Male university students
4. Men with addiction problems
5. Men bereaved by suicide
6. Young boys (13 to 18)
7. Men who are homeless
8. Men who are unemployed
9. Men with disabilities
10. Autistic Men
11. Elderly men
12. Racial minority men
13. Trans men
14. Sexual minority men (i.e., gay men, bisexual men)
15. Male immigrants, asylum seekers and refugees
16. Indigenous men
17. Men in rural communities
18. Men from traveller communities
19. Men military conscripts and veterans
20. Men in high-risk professions i.e., first responders, firefighters, police, paramedics
21. Separated fathers
22. Men living with multiple health conditions (e.g., physical and mental)
23. Men from lower income backgrounds
24. Men in the criminal justice system

Is there anything missing in this area that you think is important?

Appendix 6.3 Participant Information Sheet (Study 4, Chapter 6)

PARTICIPANT INFORMATION SHEET.

Study Title: Developing a co-designed research agenda to investigate and help reduce male suicide in the UK.
Researcher: Susie Bennett, Institute of Health and Wellbeing, University of Glasgow.
Supervisors: Professor Rory O'Connor and Dr Katie Robb.

Thank you so much for considering taking part in this research project.

This study aims to explore very sensitive topics and so it is crucial you feel comfortable about taking part and with sharing your experiences. This information sheet is to help you make an informed decision about whether you want to participate. It will give you an overview of the purpose of the research, what your participation will involve and your right to withdraw at any time. Given the complex and emotional nature of the research, you may have further questions or concerns prior to taking part. Please feel free to contact me to discuss anything in more detail. My email is: s.bennett.2@research.gla.ac.uk

I would be very happy to speak through any concerns you may have. This study will take place between May 2021 and December 2021. Take your time reading, don't feel rushed and remember, there is no obligation to take part.

Thank you.

What is the purpose of the study? The purpose of this study is to co-design a research agenda for investigating male suicide in the UK. A research agenda establishes research priorities and a set of research questions aligned to those priorities. A research agenda is a helpful tool for creating a clear framework of the questions and topics considered the most important to explore to increase understanding of an issue. It is hoped our agenda can help focus the work of academics, charities and researchers working to prevent male suicide. I would like to learn from your lived experience of suicide. I can not provide therapy or ongoing support but I would like to understand your journey from a research perspective. Male suicide is the biggest killer of men under 50 in Britain and according to the Samaritan's three-quarters of all suicides in 2018 were male. These numbers are extremely concerning. I want to build a greater understanding of what causes suicidal feelings and behaviours, and what more we can do to help men manage these thoughts and feelings.

This study aims to utilise the lived experience of people who have been bereaved by male suicide, and men who experience suicidal thoughts and feeling. I believe that people with lived experience must be at the heart of suicide research and prevention. We can only begin to understand a behaviour as complicated as suicide if we engage the wisdom and expertise of those who live that reality. In this study, we will work together to produce a research agenda for investigating and tackling male suicide in the UK.

40 people will take part in the study - 20 men who have attempted suicide or who have had suicidal thoughts and feelings, and 20 people bereaved by male suicide.

20 participants will take part in a focus group with 4 other participants to discuss potential research questions for investigating male suicide. All 40 participants will participate in two online surveys. In each survey, you will prioritise potential research questions based on which ones you think are most important. An advisory group of academic experts will help advise the study and the development of the final guidelines. By the end of the study, we will have co-designed a set of key research priorities for investigating male suicide in the UK. You can choose whether you want to take part in the focus group and the survey, or just the survey.

Why have I been invited to participate? You responded to an advertisement about the research and met the requirements to be included in this study which are:

- You are over 18 and are either:
    - a) a man who has had suicidal thoughts and feelings in the last twelve months
    - b) a man who has attempted suicide that would have been fatal if not for emergency intervention in the past five years
    - c) someone who has been bereaved by male suicide

Do I have to take part? <u>You are under no obligation to take part.</u> Given the highly personal nature of the topic, it is essential that you feel entirely comfortable to do so. Personal experiences of suicide are intimate and complex. It is entirely your decision as to whether you feel comfortable sharing your story. You are free to withdraw from the study at any time, without giving a reason.

What will happen to me if I take part?
Focus group. If you agree to participate in the focus group, you will take part in a 90-minute discussion with four other participants hosted on Zoom. Prior to the focus group, you will need to read a short background document of current recommendations for male suicide research based on prior studies. We will discuss these recommendations in each focus group - what is missing and what more should be done. Each focus group will be recorded for the audio - no filming will be required.

Survey. If you agree to participate in the survey you will need to complete two online surveys where you will be asked to rate a series of research questions based on how much of a priority you consider them to be. You will also be invited to give feedback on the final research agenda.

This study is a collaborative process between myself, you and the other participants to create a deeper understanding of suicide. I want you to feel like an active agent in developing a research agenda for investigating and tackling male suicide in the UK.

What are the possible disadvantages and risks of taking part? I realise that taking part in this research and talking about these subject matters may be distressing. In order to minimize any stress, your involvement will be completely in your control and you can withdraw at any time. Signposting to organisations who can provide further support will also be available should you wish to access them.

What are the possible benefits of taking part? Male suicide rates represent a significant public health crisis. However, academic research into what causes male suicide and how to reduce it is surprisingly lacking. This lack of research leaves vital gaps in our understanding of why so many men die by suicide in Britain and what more can be done to prevent it. Together we will produce the first UK research agenda for male suicide. We will develop the key questions for researchers to tackle to improve our understanding of male suicide risk and recovery factors. Findings will be shared with all key stakeholders involved in suicide prevention in the UK. In doing so, I hope this research can influence and inform policy, health services, suicide theory and illuminate the work of researchers, policymakers, health workers and charities currently engaged in urgent efforts to reduce male suicide rates.

Will my taking part in this study be kept confidential? Your participation and all of the information you provide in the study will be strictly confidential unless you want to be recognised as a contributor. Any personal information (including your name and contact details) will be held separately from the information you provide during the focus groups and surveys. Your information will be stored securely at Glasgow University and destroyed ten years after the project ends. Please bear in mind that if you take part in the focus group part of the study, the nature of a focus group is such that confidentiality cannot be guaranteed. Although the research team will take every precaution to maintain the confidentiality of the information you share, other members of the focus group may disclose information outside of the group. We will remind participants to respect everyone's privacy, and participants will sign a non-disclosure statement, but we cannot guarantee this. Please also be advised that if you disclose information relating to illegality, professional misconduct or abuse/harm towards others, that information may have to be escalated beyond the focus group.

What will happen to my data? Researchers from the University of Glasgow collect, store and process all personal information in accordance with the General Data Protection Regulation (2018). If you are deemed a risk to yourself or others, I may need to break confidentiality and contact emergency services, your friend/family/support network on your behalf.

What will happen to the results of the research study? The data will be stored in archiving facilities in line with the University of Glasgow retention policy of up to 10 years. After this period, further retention may be agreed or your data will be securely destroyed in accordance with the relevant standard procedures. Your identifiable information might be shared with people who check that the study is done properly and, if you agree, with other

organisations or universities to carry out research to improve scientific understanding. Your anonymised data will form part of the study results that will be published in expert journals, presentations, student dissertations/theses (if applicable) and on the internet for other researchers to use. Your name will not appear in any publication unless you would like to be recognised as a contributor.

Who has reviewed the study? This project has been reviewed by the College of Medical, Veterinary & Life Sciences Ethics Committee.

Contact for Further Information. If you have any questions or require more information please contact me on s.bennett.2@research.gla.ac.uk

Thank you for taking the time to read this information sheet.

SUPPORT FOR PEOPLE EXPERIENCING SUICIDAL THOUGHTS AND FEELINGS.

At some time in all of our lives, we feel down, depressed or low. If you are feeling down, or are worried about something and would like to speak to someone, please see the list of organisations below. You may also wish to contact your GP or another healthcare professional.

If you think your life or someone's life is in danger you should visit an emergency department or call an ambulance by dialling 999.

NHS 24. Health Information and Self Care Advice

NHS 24 provides comprehensive up-to-date health information and self-care advice. If your GP surgery is closed and you can't wait until it opens, you can call NHS 24. They will direct you to the right care for you or the person you are calling for. This may be to your local Health Board's out of hours services, Accident and Emergency department, or the Ambulance Service. If appropriate, they may recommend some steps you can take to look after yourself at home.
https://www.nhs.uk **- Tel: 111**

Samaritans

Samaritans is a support service available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide.
https://www.samaritans.org/ - Tel: 08457 90 90 90

CALM (campaign against living miserably)

CALM is leading a movement against suicide, with a particular focus on men who are often more at risk. They have a national helpline, webchat and online resources for support
www.thecalmzone.net Helpline 0800 58 58 58 - London 080 802 58 58 OPEN 7 days a week 17.00-00.00
Email info@thecalmzone.net - Webchat www.thecalmzone.net/help/webchat/

PAPYRUS

This is a national charity which helps to stop young suicide. They run HOPELineUK. HOPELineUK give practical advice and information to: children, teenagers and young people up to the age of 35 who are worried about how they are feeling, and anyone who is concerned about a young person.
https://www.papyrus-uk.org - Telephone: 0800 068 41 41 (open Mon-Fri: 10am to10pm, weekends: 2pm to 10pm & bank holidays: 2pm to 5pm) - SMS: 07786 209697 - Email: pat@papyrus-uk.org

The Mix

They offer a free, confidential helpline service for young people under 25.
Telephone: 0808 808 4994 (Open 11am – 11pm 7 days a week) E-mail: www.getconnected.org.uk/email-us/
Webchat: through the website: www.getconnected.org.uk

Men's Minds Matter

Men's Minds Matter is a not-for-profit organisation dedicated to the prevention of male suicide by building psychological resilience and emotional strength. The website has many resources and guides relating to male suicide including anger, stress, depression and how to support a man in crisis.
Website: https://www.mensmindsmatter.org/

Andy's Club

Andy's Club are talking club's for men. They have numerous clubs across the country and a national online group for those outside of current club catchment areas.
Website: https://andysmanclub.co.uk/

Maytree (London)

Maytree's house is open 365 days a year for people when they're feeling suicidal. Maytree provide a unique residential service for people in suicidal crisis so they can talk about their suicidal thoughts and behaviour. They offer a free 4 night, 5 day one-off stay to adults over the age of 18 from across the UK.
Website: https://www.maytree.org.uk/

The Listening Place (London)

Face-to-face support for those who feel life is no longer worth living. Carefully trained and selected volunteers, working in a supportive environment and backed by experienced mental health professionals, have regular meetings with people who are struggling with suicidal thoughts, plans and actions.
Website: https://listeningplace.org.uk/

James Place (Liverpool)

James' Place, work with men who are experiencing a suicidal crisis. Their centre in Liverpool supports men from Merseyside who are referred by health professionals or have self-referred.
Website: https://www.jamesplace.org.uk/

Sean's Place (Liverpool)

Sean's Place aim is to improve men's mental health and well-being across Sefton and Liverpool City Region through sessions specifically identified to improve confidence and self-esteem for men whilst reducing symptoms of depression, stress and anxiety.
Website: https://seansplace.org.uk/

1. ADDITIONAL SUPPORT LINES

Alcohol Change

Alcohol Change UK is a UK alcohol charity. Their website links to a wide range of support services should you wish to speak to or get advice about your drinking. https://alcoholchange.org.uk/

Smokeline

Smokeline is Scotland's national stop smoking helpline, open every day from 8am-10pm. They have helped thousands of people and can help you too. Smokeline advisers can guide you through what's helped other smokers, and help you work out what's most likely to work for you.
http://www.canstopsmoking.com/ - Tel: 0800 848 84 84

National Debtline

Provides free, independent, confidential advice on a self-help basis. You can contact them over the telephone, by e-mail or letter.

www.nationaldebtline.org - Telephone: 0808 808 4000 Monday to Friday 9am-8pm and Saturday 9.30am-1pm
Email: visit website to use email contact form

Switchboard – LGBT + Helpline

Switchboard gives practical and emotional support for lesbian, gay, bisexual or transgender people. You can talk to them about any issue.
Webchat: through the website - www.switchboard.lgbt - Telephone: 0300 330 0630 (open 10am – 11pm)
E-mail: chris@switchboard.lgbt

2. SUPPORT FOR PEOPLE BEREAVED BY SUICIDE.

Survivors of Bereavement by Suicide (SOBS)

SOBS offers support for those bereaved or affected by suicide through a helpline answered by trained volunteers who have been bereaved by suicide and a network of local support groups.
www.uk-sobs.org.uk / Helpline 0300 111 5065 Everyday 9.00-21.00 / Email sobs.support@hotmail.com

Help is at Hand

Produced by the Department of Health, this is a resource for people bereaved by suicide and other sudden, traumatic death in England and Wales. The booklet can be read online at: www.supportaftersuicide.org.uk/support-guides/help-is-at-hand/ or printed copies can be ordered by phoning 0300 123 1002 quoting 2901502/Help is at Hand.

The Compassionate Friends

This service supports bereaved parents and their families. They have a Shadow of Suicide (SOS) group that can put parents in touch with other parents who have lost a child to suicide.
Telephone: 0345 123 2304 (10am-4pm & 7pm-10pm daily) / Email: helpline@tcf.org.uk / Website: www.tcf.org.uk

Cruse Bereavement Care

Cruse offer free, confidential help to bereaved people.
Telephone: 0844 477 9400 (9.30am-5pm, Monday-Friday – excludes bank holidays, with extended hours until 8pm Tuesdays, Wednesdays and Thursdays) / Email: helpline@cruse.org.uk / Website: www.cruse.org.uk

Appendix 6.4 Consent Form (Study 4, Chapter 6)

University of Glasgow | College of Medical, Veterinary & Life Sciences

Title of Project: Developing a co-designed research agenda to investigate and help reduce male suicide in the UK.

Name of Researchers: Susie Bennett, Professor Rory O'Connor, Dr Katie Robb and Dr Tiago Zortea

Please bear in mind that if you take part in the focus group part of the study, the nature of a focus group is such that confidentiality cannot be guaranteed. Although the research team will take every precaution to maintain the confidentiality of the information you share, other members of the focus group may disclose information outside of the group. We will remind participants to respect everyone's privacy, and participants will sign a non-disclosure statement, but we cannot guarantee this. Please also be advised that if you disclose information relating to illegality, professional misconduct or abuse/harm towards others, that information may have to be escalated beyond the focus group.

CONSENT FORM	Please initial box
I confirm that I have read and understood the Participant Information Sheet.	☐
I confirm that I have read and understood the Privacy Notice.	☐
I have had the opportunity to think about the information and ask questions, and understand the answers I have been given.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐
I confirm that I agree to the way my data will be collected and processed and that data will be stored for up to 10 years in University archiving facilities in accordance with relevant Data Protection policies and regulations.	☐
I understand that all data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers.	☐

I agree that my name, contact details and data described in the information sheet will be kept for the purposes of this research project.	☐
I understand that if I withdraw from the study, my data collected up to that point will deleted.	☐
(If participating in a focus group) **I agree to my focus group being recorded and for the focus group data to be available for future research.**	☐
(If participating in a focus group) **I understand that my information and things that I say in a focus group may be quoted in reports and articles that are published about the study, but my name or anything else that could tell people who I am will not be revealed.**	☐
I agree that should significant concerns regarding my mental health arise during my participation in the study that a member of an appropriate clinical team will be immediately informed.	☐
I agree to take part in the study.	☐

_____

Name of participant Date Signature

_____

Researcher Date Signature

Appendix 6.5 Item Scoring, Round 1, Participant Update, Sample (Study 4, Chapter 6)

NOTE: Screenshot of PDF document sent to participants.

University of Glasgow | College of Medical, Veterinary & Life Sciences

Developing a co-designed research agenda to investigate and help reduce male suicide.

Researcher: Susie Bennett, Institute of Health and Wellbeing, University of Glasgow.
Supervisors: Professor Rory O'Connor and Dr Katie Robb.

ROUND 1 RESULTS.

Thank you so much for taking the time to participate in our study.

You are part of a "Delphi" study, which means a study that builds consensus via expert views. There are various ways a Delphi study can be conducted using different panels of experts. For example, academic researchers can be an expert panel, or doctors, or clinical psychologists.

In this study design, we choose people with lived experience to be our expert panel, though we also worked very closely with other academic experts to develop the original research questions.

You have kindly completed round 1 of the survey. We have reviewed all your answers to decide which items should be included in the research agenda, which items should be rejected, and which items need re-rating in this final survey round.

HOW THE SCORING WORKS.

The scoring was first based on splitting all participants into three different groups:

1) Men who have attempted suicide
2) Men who experience thoughts and feelings of suicide
3) People bereaved by male suicide

I know that for many of you, your reality often means you belong to two or more of these groups. For the purposes of the scoring, we had to create strict definitions based on the hierarchy shown above. i.e., if you identify as a man who has attempted suicide and have thoughts of suicide, you were placed in the first group "attempted suicide" for scoring purposes.

Accepted Research Agenda Items. Items have been accepted onto the final research agenda where 80% of all participants endorsed the item as "Important" or "Essential".

Research Agenda Items for Re-Rating. In this final round of the study, we would like you to re-rate certain items. These are questions that were either:

1. Endorsed as "Important" or "Essential" by over 80% of one of the participant groups (i.e., 80% of people bereaved by male suicide felt this item was "Important" or "Essential")

2. Endorsed as either "Important" or "Essential" by over 70% of two of the participant groups

3. Is a new item suggested by a participant in round 1 that we felt was not covered by an existing question.

Rejected Research Agenda Items. All other items were rejected from the research agenda.

So far, we have:

- 76 items that have been accepted
- 32 items that need to be re-rated
- 10 new items to be re-rated
- 26 items rejected

In this final round, all items endorsed by 80% of all participants as either "Important" or "Essential will be included in the research agenda.

Click here to access Round 2 of the survey for completion by Sunday 24 April.

In the above survey link you will find a breakdown of all items that have been accepted and rejected as well as those for re-rating. For your additional interest, on the following pages we have included an overview of the top rated items and a breakdown of the scoring per particiapnt group.

Thank you again for your time and support.

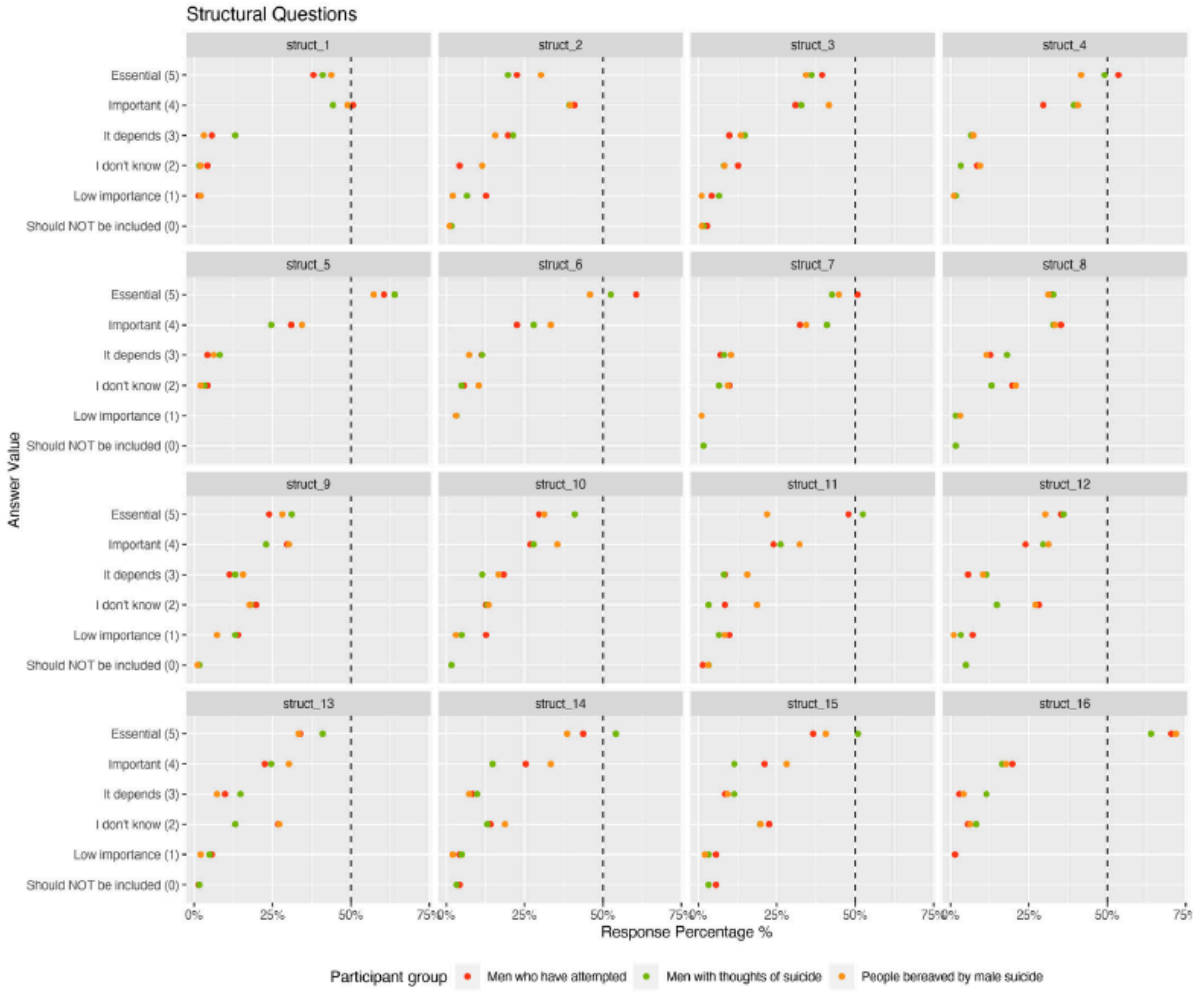
TOP RATED QUESTIONS.

The following questions are those which received the most support from all participants following Round 1 - endorsement percentage is shown in the brackets.

1. Investigating loneliness and isolation for men who are suicidal (98%)
2. Exploring feelings of failure in men who are suicidal (97%)
3. Exploring the main sources of stress and emotional pain for men who are suicidal (96%)
4. Exploring the best ways to support young men who are suicidal (95%)
5. Exploring the best ways to support men who are suicidal to repair harmful thoughts and feelings about themselves (94%)
5. Exploring how men who are suicidal understand, manage and express their emotions and emotional pain (94%)
6. Exploring who men who are suicidal talk to about their emotional problems: what helps, what doesn't, what could help? (94%)
7. Exploring effective interventions for men who cannot afford / access therapy (93%)
7. Exploring the experience of men who are suicidal of seeking professional support: what helps, what doesn't, what could help? (93%)
7. Exploring different intervention types (i.e. talk therapy, medication): what helps, what doesn't, what could help? (93%)
7. Exploring the experiences of men who are suicidal of seeking help: what helps, what doesn't, what could help? (93%)
7. Exploring how young men seek help (i.e., talking to teachers, peers, medical professionals, chat rooms) and cope with their problems (93%)

EXPLORING STRUCTURAL FACTORS

These questions explore male suicide risk and recovery factors related to structural factors such as political, social and economic conditions. Which questions do you think are most important for us to study?



struct_1 = Work stress and male suicide risk i.e., work pressures, insecure work conditions, workplace bullying, not doing work that makes use of skills and abilities

struct_2 = Exploring the best ways that workplaces can support men who are suicidal

struct_3 = Understanding the importance of work as providing meaning, fulfilment and identity to men who are suicidal

struct_4 = Unemployment and male suicide risk

struct_5 = Financial pressures/debt and male suicide risk

struct_6 = Poverty and male suicide risk

struct_7 = Insecure housing/homelessness and male suicide risk

struct_8 = Legal issues and male suicide risk

struct_9 = Impact of current and/or historical policy changes and male suicide risk i.e., government spending cuts and male suicide risk

struct_10 = Social media and male suicide risk

struct_11 = Misandry (prejudice against men such as discrimination against men, negative messages about men) and male suicide risk

struct_12 = Racism and male suicide risk

struct_13 = Disability discrimination and male suicide risk

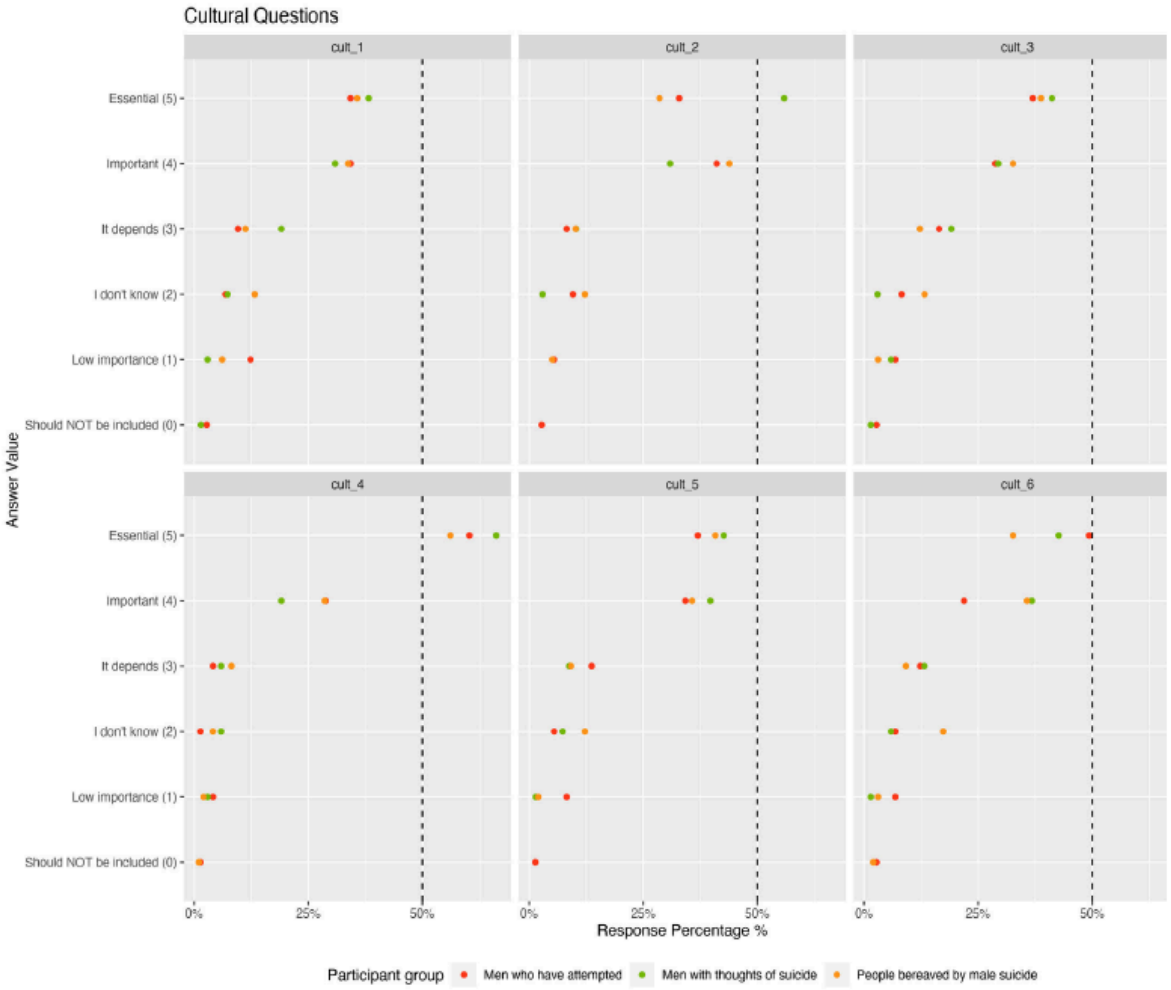
struct_14 = Homophobia/biphobia and male suicide risk

struct_15 = Transphobia and male suicide risk

struct_16 = The combined impact of multiple structural factors and male suicide risk i.e., being unemployed, having a disability and living in insecure housing

EXPLORING CULTURAL FACTORS

These questions explore risk and recovery factors relating to social/cultural beliefs and expectations for men and male behaviour. Which questions do you think are most important for us to study?



cult_1 = Exploring what 'being a man' means to men who are suicidal

cult_2 = Exploring how men who are suicidal perceive society as viewing men and how these views have changed over time

cult_3 = Exploring ideas of masculinity that men who are suicidal find helpful (i.e., how can masculinity and male strengths be used to protect men from suicide? What sort of masculinity would men like to see celebrated and uplifted in our cultures?)

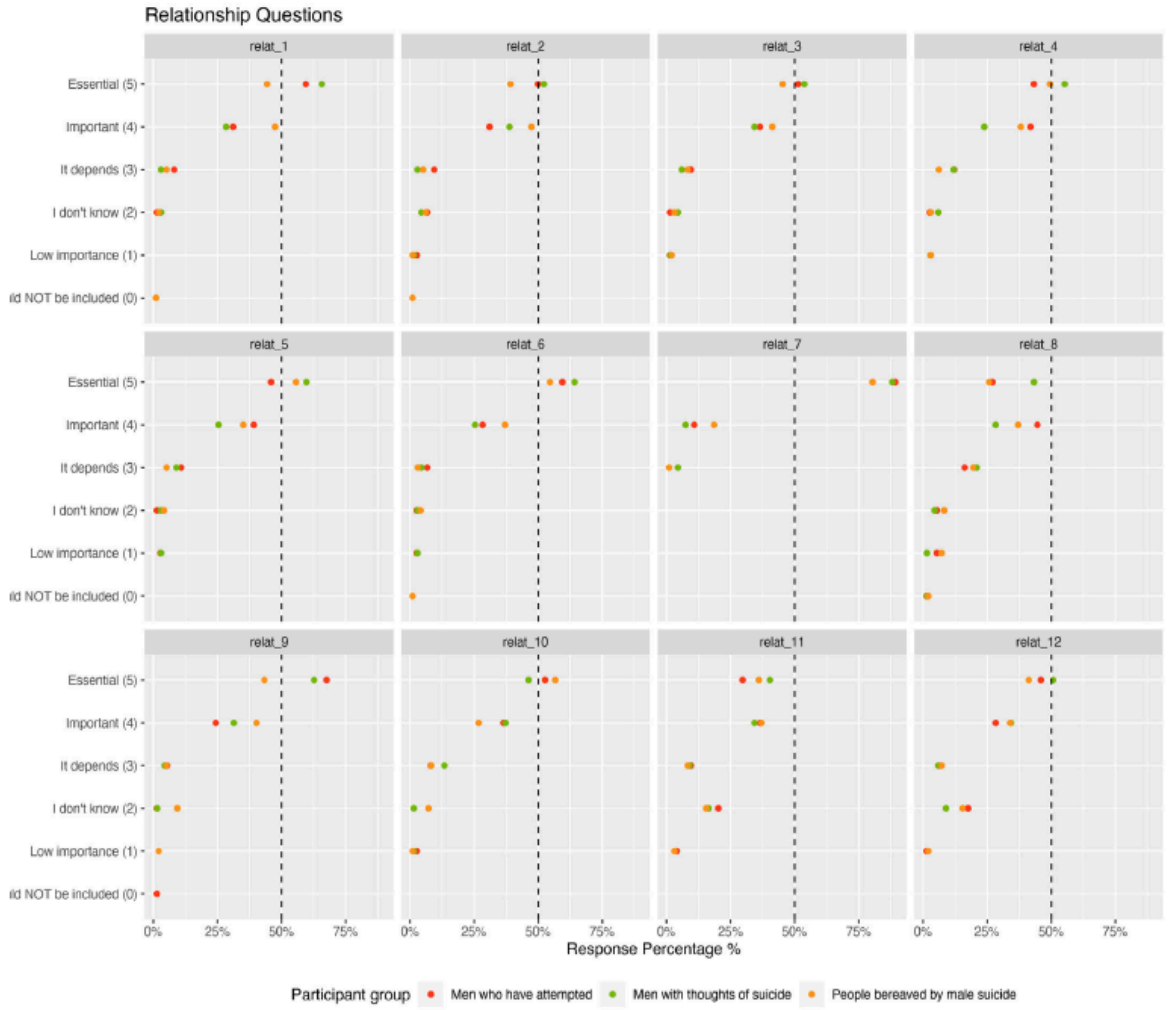
cult_4 = Exploring differences in how male and female distress is understood and responded to by people

cult_5 =Exploring how men who are suicidal develop and form their ideas of masculinity (who are the main influences on ideas and behaviours i.e., family, friends, media, education, religion etc)

cult_6 = Exploring the presence or absence of male role models in the lives of men who are suicidal

EXPLORING MEN'S RELATIONSHIPS

These questions explore risk and recovery factors that relate to men's relationships with other people. Which questions do you think are most important for us to study?



relat_1 = Understanding what meaningful connection with significant others means for men who are suicidal

relat_2 = Understanding how men who are suicidal build intimacy and connection with significant others

relat_3 = Investigating challenges in creating and/or sustaining meaningful connections with significant others

relat_4 = Investigating how men who are suicidal deal with conflict in their relationships with significant others

relat_5 = Investigating how connections with significant others can protect men who are suicidal from suicide

relat_6 = Investigating the best ways to support men to create and/or sustain meaningful relationships with others

relat_7 = Investigating loneliness and isolation for men who are suicidal

relat_8 = Investigating the absence of a romantic partner and male suicide risk

relat_9 = Investigating domestic abuse (physical, sexual, emotional, and/ or psychological) and male suicide risk

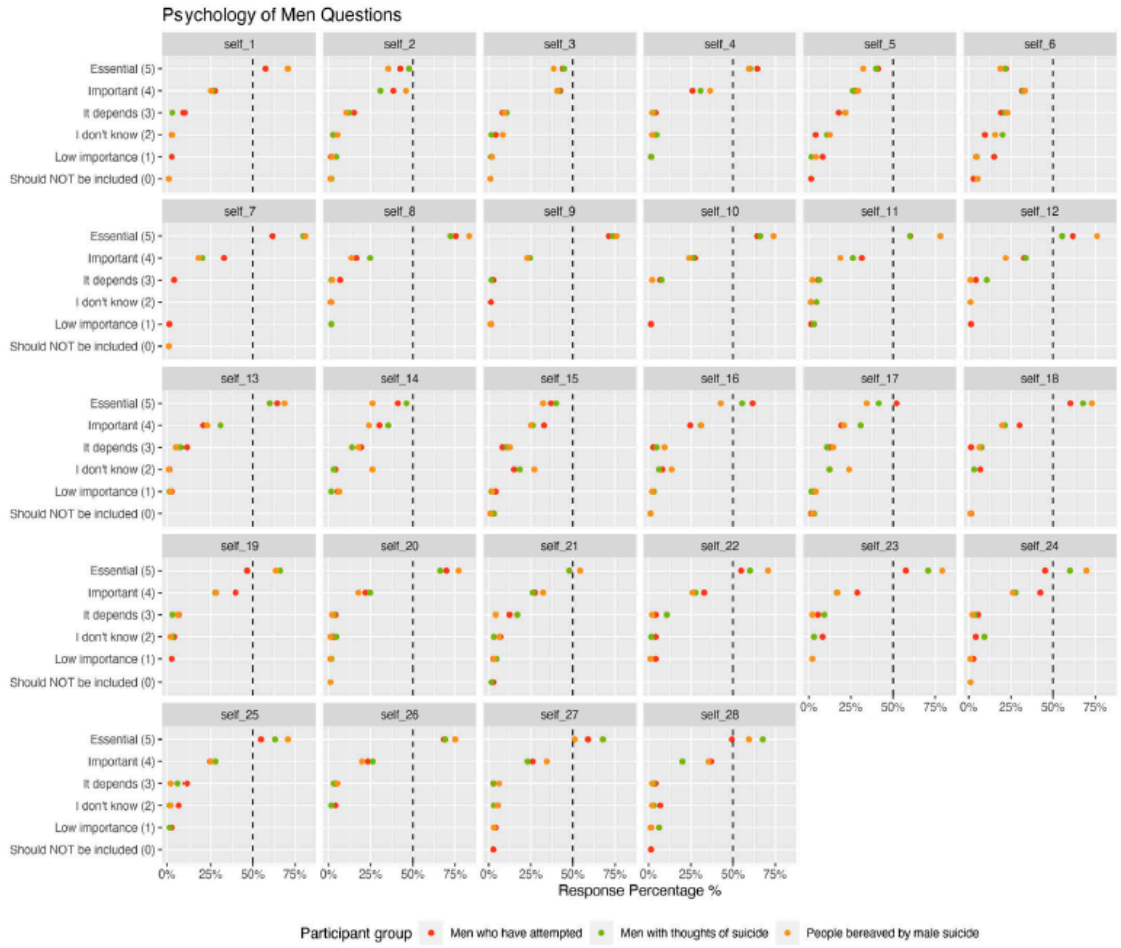
relat_10 = Investigating romantic breakups and male suicide risk

relat_11 = Investigating parenting challenges and male suicide risk

relat_12 = Investigating parental alienation and male suicide risk

EXPLORING THE PSCYHOLGOY OF MEN

These questions explore suicide risk and recovery factors that relate to things happening inside the psychology of individual men i.e., the emotions and thoughts that men experience that may increase suicide risk. Our emotions and thoughts are influenced by many things including biological and external factors - such as work, family, and other cultural and structural factors already discussed. In this section, we are interested in what is happening inside the psychology of men due to all these different factors. Which questions do you think are most important for us to study?



self_1 = Exploring self-esteem (i.e., positive and/or negative thoughts and feelings about yourself) as a male suicide risk and recovery factor

self_2 = Exploring self-reliance (i.e., relying on yourself rather than other people) as a male suicide risk and recovery factor

self_3 = Exploring control and agency (i.e., having the ability and power to do the things you want and to make your own choices) as male suicide risk and recovery factors

self_4 = Exploring having a sense of purpose and meaning as male suicide risk and recovery factor

self_5 = Exploring how men who are suicidal think and feel about their body and physical appearance

self_6 = Exploring the relationship men who are suicidal have with food and diet

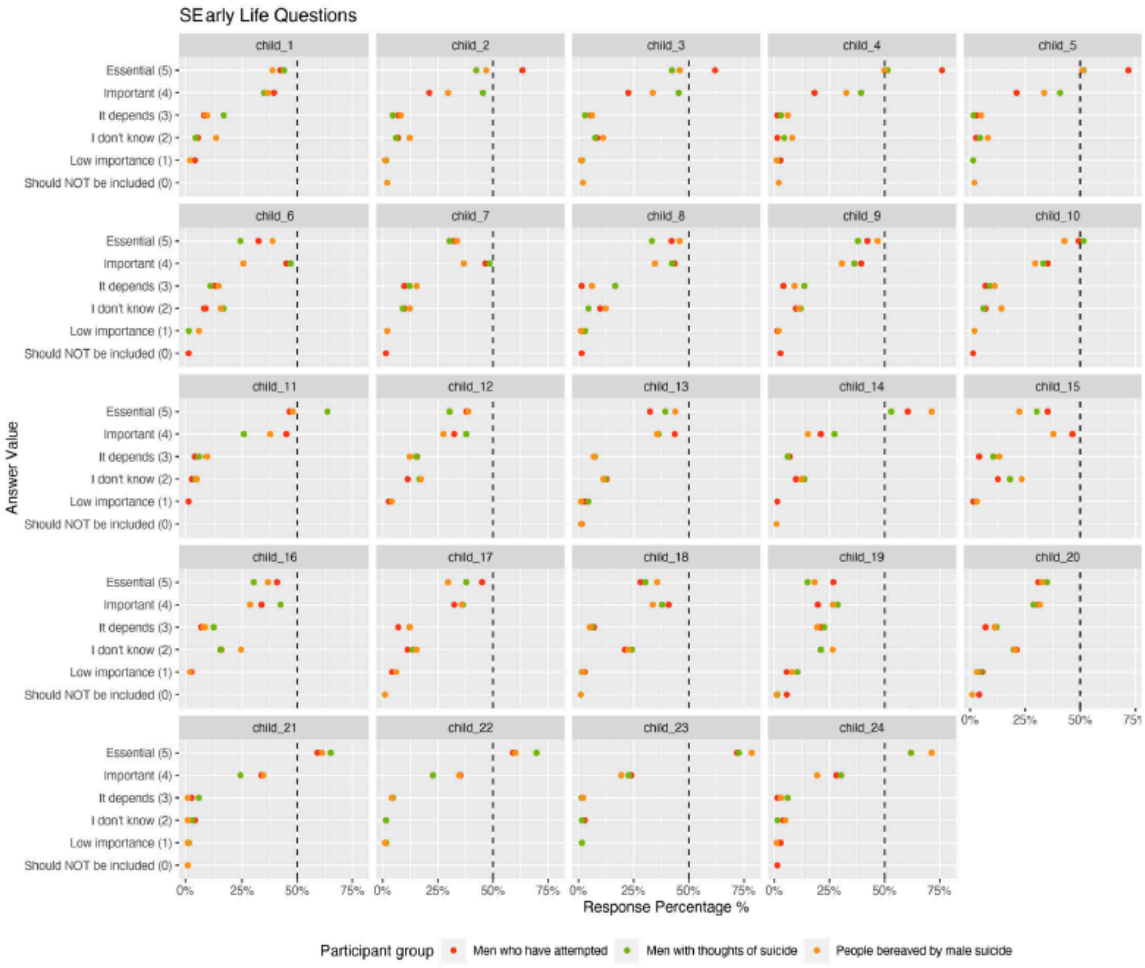
self_7 = Exploring feelings of failure in men who are suicidal

self_8 = Exploring the best ways to support men

who are suicidal to repair harmful thoughts and feelings about themselves
self_9 = Exploring the main sources of stress and emotional pain for men who are suicidal
self_10 = Exploring how men who are suicidal understand, manage and express their emotions and emotional pain
self_11 = Exploring the most effective ways of supporting men who are suicidal to manage their emotions and emotional pain
self_12 = Exploring who men who are suicidal talk to about their emotional problems: what helps, what doesn't, what could help?
self_13 = Exploring the coping strategies men who are suicidal use (i.e., food, alcohol, drugs, medication, gambling, gaming, the internet etc.)
self_14 = Exploring male sexuality (i.e., feeling sexually desirable, frequency of sex, sexual satisfaction, porn/masturbation, virginity, attraction to minors etc) and male suicide risk
self_15 = Exploring sexual minority men (i.e., gay/bi/pansexual men) and male suicide risk
self_16 = Exploring surviving sexual abuse/assault and male suicide risk
self_17 = Exploring false accusations of sexual assault (e.g., reports to police or authorities, rumours/ gossip) and male suicide risk
self_18 = Investigating the relationship between having a mental health condition (i.e., depression, social anxiety, bipolar) and male suicide risk
self_19 = Exploring the past-thinking and future-thinking of men who are suicidal (e.g., constantly thinking about what has gone wrong in the past/feeling worried about the future)
self_20 = Understanding men's suicidal thoughts and feelings (i.e., how do thoughts of suicide develop, what are the contents of men's suicidal thoughts, what triggers thoughts, how long do they last, are thoughts heightened at certain times of day/night, how do thoughts of suicide impact other areas of men's lives?)
self_21 = Exploring what suicide means to men who are suicidal
self_22 = Exploring how men manage thoughts of suicide and what prevents men from acting on them
self_23 = Exploring what triggers a shift from thinking about suicide to planning a suicide
self_24 = Exploring the thought patterns and emotional states of men when planning suicidal action
self_25 = Exploring the attitude of men who are suicidal towards seeking help
self_26 = Exploring the experiences of men who are suicidal of seeking help: what helps, what doesn't, what could help?
self_27 = Exploring how men's mental health and suicide are represented in society and how these ideas impact men who are suicidal
self_28 = Exploring what language and messages are best to engage men who are suicidal around mental health issues

EXPLORING EARLY LIFE EXPEREINCES

These questions explore experiences in early life - up to the age of 18 - that may increase suicide risk for some men. Which questions do you think are most important for us to study?

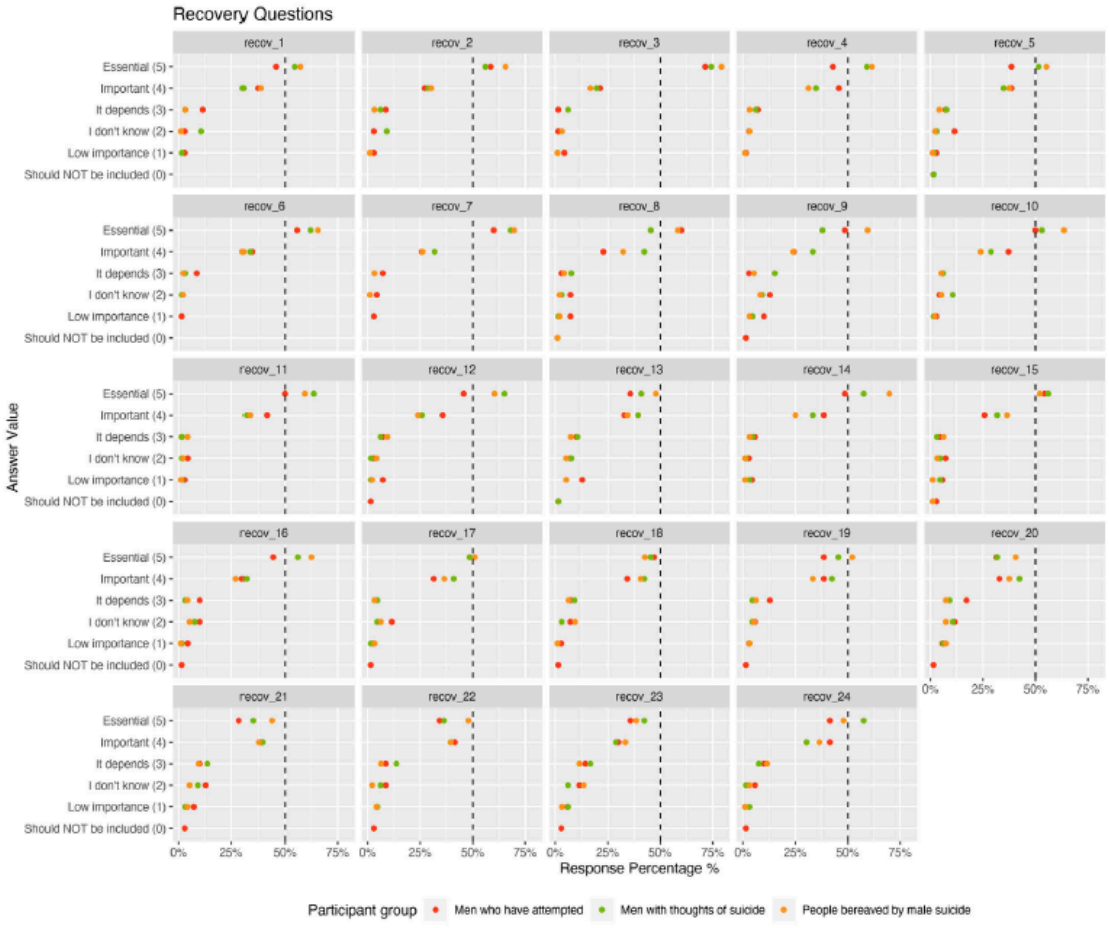


child_1 = Investigating the impact of early life bullying and male suicide risk
child_2 = Experiencing or witnessing sexual abuse
child_3 = Experiencing or witnessing physical abuse
child_4 = Experiencing or witnessing psychological/ emotional abuse
child_5 = Experiencing or witnessing physical/ emotional neglect
child_6 = Caregiver(s) struggling with personal problems (e.g., financial, legal, emotional)
child_7 = Caregiver relationship conflict - including separation and/or divorce
child_8 = Mental health problems in the caregiving home
child_9 = Addiction problems in the caregiving home
child_10 = Caregiver absence, abandonment or estrangement
child_11 = Family controlling behaviours, pressure and/or expectations
child_12 = Sibling abuse
child_13 = Death of a significant other
child_14 = Death by suicide of a significant other
child_15 = Growing up with a disability / physical health challenges
child_16 = Growing up with neuro-divergency (such as ADHD or Autism)
child_17 = Growing up in poverty
child_18 = Growing up in care
child_19 = Moving multiple times in childhood

child_20 = Growing up as a minority (i.e., racial, sexual, trans, religious)
child_21 = Exploring how mental health problems - including suicidal thoughts, feelings and attempts - develop in young men
child_22 = Exploring how young men seek help (i.e., talking to teachers, peers, medical professionals, chat rooms) and cope with their problems
child_23 = Exploring the best ways to support young men who are suicidal
child_12 = Exploring the long-term impact of early life challenges for men who are suicidal

EXPLORING SUPPORT AND RECOVERY

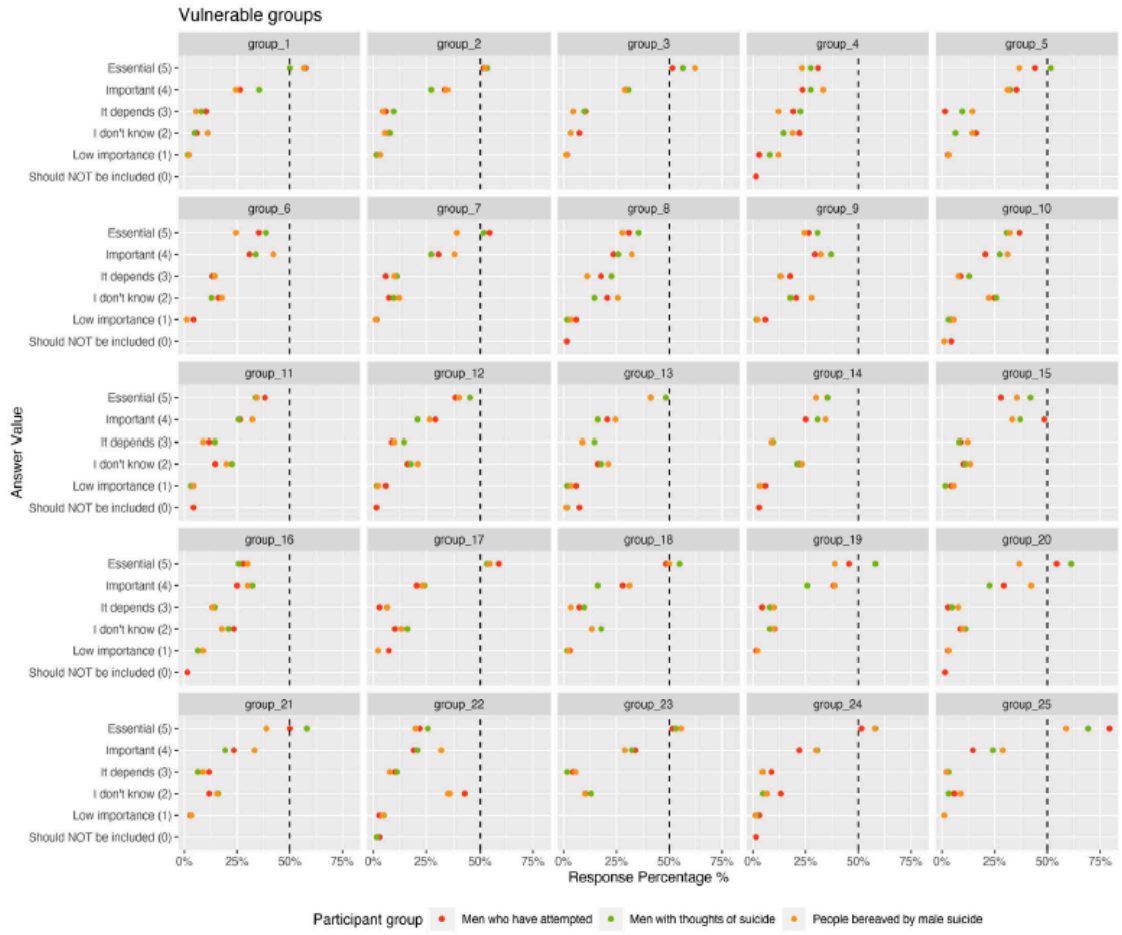
These questions explore experiences relating to accessing support and learning to manage suicidal thoughts, feelings and behaviours. Which questions do you think are most important for us to study?



recov_1 = Exploring what 'recovery' means for men who have attempted suicide and men's reasons for living
recov_2 = Understanding how men cope after a suicide attempt: what helps, what doesn't, what could help?
recov_3 = Exploring effective interventions for men who cannot afford / access therapy
recov_4 = Exploring the experience of men who are suicidal of seeking support from significant others: what helps, what doesn't, what could help?
recov_5 = Exploring the experiences of significant others when supporting men who are suicidal: what helps, what doesn't, what could help?
recov_6 = Exploring the experience of men who are suicidal of seeking professional support: what helps, what doesn't, what could help?
recov_7 = Exploring different intervention types (i.e. talk therapy, medication): what helps, what doesn't, what could help?
recov_8 = Exploring men's relationship with health-care professionals: what helps, what doesn't, what could help?
recov_9 = Exploring emergency admission and discharge: what helps, what doesn't, what could help?
recov_10 = Exploring the most effective support in the six months following a suicide attempt: what helps, what doesn't, what could help?
recov_11 = Exploring the most effective long-term support for men who are suicidal: what helps, what doesn't, what could help?
recov_12 = Exploring what professional support men who are suicidal want to receive (i.e., What areas of life do men want help with? What skills do men want support to build?)
recov_13 = Exploring the experiences of health service professionals (e.g., doctors, therapists, psychologists, psychiatrists etc.) of working with men who are suicidal
recov_14 = Understanding what training healthcare professionals need to better identify and engage at-risk men
recov_15 = Exploring differences in how men and women present suicide risk and the best gender-sensitive screening tools for health services professionals
recov_16 = Understanding how different services can work together better (i.e., how can the criminal justice system work with mental health care?)
recov_17 = Exploring how academic researchers and health care professionals can work together to incorporate research findings into services
recov_18 = Exploring how to best measure the outcome of interventions, i.e., increased self-esteem and reduced suicide risk
recov_19 = Exploring the experiences of men who are suicidal of accessing support in their community: what helps, what doesn't, what could help?
recov_20 = Exploring the experiences of community members who support men who are suicidal: what helps, what doesn't, what could help?
recov_21 = Exploring effective community members who can spot and engage at-risk men
recov_22 = Exploring effective training for community members to support men who are suicidal
recov_23 = Exploring effective community mental health role models for men who are suicidal
recov_24 = Exploring how to create communities that support men who are suicidal better

EXPLORING VULNERABLE MEN

The research questions suggested in this survey apply to all men irrespective of their background. However, certain groups of men have been identified as at particular risk of suicide. Of these populations which do you consider to be of high priority?



group_1 = Young boys (13 to 18)
group_2 = Male university students
group_3 = Middle-aged men
group_4 = Elderly men
group_5 = Separated fathers
group_6 = Men with disabilities
group_7 = Men living with multiple health conditions (e.g., physical and mental)
group_8 = Men with autism
group_9 = Men with ADHD
group_10 = Indigenous men
group_11 = Racial minority men
group_12 = Sexual minority men (i.e., gay men, bisexual men)
group_13 = Trans men
group_14 = Male immigrants, asylum seekers and refugees
group_15 = Men from lower income backgrounds
group_16 = Men in rural communities
group_17 = Men military conscripts and veterans
group_18 = Men in high-risk professions i.e., first responders, firefighters, police, paramedics
group_19 = Men who are unemployed
group_20 = Men who are homeless
group_21 = Men in the criminal justice system
group_22 = Men from traveller communities
group_23 = Men with addiction problems
group_24 = Men bereaved by suicide
group_25 = Male survivors of abuse

Appendix 6.6 Item Scoring, Round 2 (Study 4, Chapter 6)

Overall Level of Consensus for each item

Thematic Domain	% All Participants	% Attempt	% Ideation	% Bereaved	Consensus Round	Decision
Individual Item (abbreviated)						
Thematic Domain 1: Structural Factors						
• Financial pressures/debt and male suicide risk	90	92	89	91	1	Accept
• Work stress and male suicide risk	88	88	85	83	1	Accept
• The combined impact of multiple structural factors and male suicide risk	87	89	82	90	1	Accept
• Unemployment and male suicide risk	84	84	88	83	1	Accept
• Poverty and male suicide risk	80	82	79	80	1	Accept
• Insecure housing/homelessness and male suicide risk	80	81	83	80	1	Accept
• Understanding the importance of work as providing meaning, fulfilment and identity to men who are suicidal	81	81	81	82	2	Accept

• Education systems and male suicide risk	79	77	74	82	2*	Reject
• Exploring the impact of government suicide prevention initiatives over time	69	68	64	73	2*	Reject
• Misandry and male suicide risk	60	68	76	46	2	Reject
• Homophobia/biphobia and male suicide risk	69	68	67	73	1	Reject
• Exploring the best ways that workplaces can support men who are suicidal	65	64	61	71	1	Reject
• Social media and male suicide risk	64	55	70	68	1	Reject
• Legal issues and male suicide risk	64	66	64	64	1	Reject
• Transphobia and male suicide risk	62	55	61	70	1	Reject
• Racism and male suicide risk	61	58	64	62	1	Reject
• Disability discrimination and male suicide risk	61	55	65	63	1	Reject
• Impact of current and/or historical policy changes and male suicide risk i.e., government spending cuts and male suicide risk	55	51	56	58	1	Reject
Thematic Domain 2: Cultural Factors						
• Exploring differences in how male and female distress is understood and responded to by people	86	89	85	85	1	Accept

• Exploring how men who are suicidal develop and form their ideas of masculinity	81	79	81	82	2	Accept
• Exploring how men who are suicidal perceive society as viewing men and how these views have changed over time	78	85	81	72	2	Reject
• Exploring the presence or absence of male role models in the lives of men who are suicidal	76	77	79	73	2	Reject
• Exploring ideas of masculinity that men who are suicidal find helpful	74	70	81	73	2	Reject
• Exploring what being a man, means to men who are suicidal	68	69	69	69	1	Reject
Thematic Domain 3: Relationships with Others						
• Investigating loneliness and isolation for men who are suicidal	98	100	96	99	1	Accept
• Understanding what meaningful connection with significant others means for men who are suicidal	91	91	94	92	1	Accept
• Investigating the best ways to support men to create and/or sustain meaningful relationships with others	89	88	90	92	1	Accept
• Investigating domestic abuse (physical, sexual, emotional, and/ or psychological) and male suicide risk	88	92	94	84	1	Accept
• Investigating challenges in creating and/or sustaining meaningful connections with significant others	87	88	88	87	1	Accept
• Investigating how connections with significant others can protect men who are suicidal from suicide	87	85	85	91	1	Accept

• Understanding how men who are suicidal build intimacy and connection with significant others	86	81	91	87	1	Accept
• Investigating romantic breakups and male suicide risk	85	89	84	84	1	Accept
• Investigating how men who are suicidal deal with conflict in their relationships with significant others	84	85	79	88	1	Accept
• Investigating parental alienation and male suicide risk	79	81	77	78	2	Reject
• Investigating the absence of a romantic partner and male suicide risk	68	66	79	62	2	Reject
• Investigating parenting challenges and male suicide risk	66	74	60	65	2	Reject
Thematic Domain 4: Relationship with Self						
• Exploring feelings of failure in men who are suicidal	97	95	99	99	1	Accept
• Exploring the main sources of stress and emotional pain for men who are suicidal	96	95	97	99	1	Accept
• Exploring how men who are suicidal understand, manage and express their emotions and emotional pain	94	92	93	98	1	Accept
• Exploring who men who are suicidal talk to about their emotional problems: what helps, what doesn't, what could help?	94	95	90	98	1	Accept
• Exploring the best ways to support men who are suicidal to repair harmful thoughts and feelings about themselves	94	92	96	97	1	Accept

• Exploring the experiences of men who are suicidal of seeking help: what helps, what doesn't, what could help?	93	92	94	95	1	Accept
• Exploring self-esteem (i.e., positive and/or negative thoughts and feelings about yourself) as a male suicide risk and recovery factor	92	85	96	96	1	Accept
• Exploring the most effective ways of supporting men who are suicidal to manage their emotions and emotional pain	92	92	87	97	1	Accept
• Understanding men's suicidal thoughts and feelings	92	92	91	95	1	Accept
• Exploring having a sense of purpose and meaning as male suicide risk and recovery factor	92	91	90	96	1	Accept
• Exploring how men manage thoughts of suicide and what prevents men from acting on them	91	88	88	97	1	Accept
• Investigating the relationship between having a mental health condition and male suicide risk	90	89	90	93	1	Accept
• Exploring the past-thinking and future-thinking of men who are suicidal	90	86	93	92	1	Accept
• Exploring what triggers a shift from thinking about suicide to planning a suicide	90	86	88	96	1	Accept
• Exploring the thought patterns and emotional states of men when planning suicidal action	90	86	87	96	1	Accept
• Exploring the coping strategies men who are suicidal use	89	85	91	92	1	Accept
• Exploring what language and messages are best to engage men who are suicidal around mental health issues	89	86	87	95	1	Accept

• Exploring the attitude of men who are suicidal towards seeking help	88	80	90	96	1	Accept
• Exploring how men's mental health and suicide are represented in society and how these ideas impact men who are suicidal	86	85	90	86	1	Accept
• Exploring control and agency as male suicide risk and recovery factors	83	86	87	80	1	Accept
• Exploring surviving sexual abuse/assault and male suicide risk	81	86	87	74	1	Accept
• Exploring self-reliance (i.e., relying on yourself rather than other people) as a male suicide risk and recovery factor	80	80	79	82	1	Accept
• Exploring trauma and male suicide risk	94	98	91	93	2	Accept
• Exploring what suicide means to men who are suicidal	86	89	80	86	2	Accept
• Exploring male self-harm and suicide risk	83	81	81	86	2	Reject
• Exploring male sexuality and male suicide risk	65	68	78	54	2	Reject
• Exploring false accusations of sexual assault (e.g., reports to police or authorities, rumours/gossip) and male suicide risk	60	62	70	54	2	Reject
• Exploring how men who are suicidal think and feel about their body and physical appearance	65	68	66	63	1	Reject
• Exploring sexual minority men (i.e., gay/bi/pansexual men) and male suicide risk	63	70	66	58	1	Reject
• Exploring the relationship men who are suicidal have with food and diet	53	53	54	54	1	Reject

Thematic Domain 5: Early Life Experiences						
• Exploring the best ways to support young men who are suicidal	95	95	94	98	1	Accept
• Exploring how young men seek help (i.e., talking to teachers, peers, medical professionals, chat rooms) and cope with their problems	93	93	91	95	1	Accept
• Exploring how mental health problems - including suicidal thoughts, feelings and attempts - develop in young men	92	92	88	96	1	Accept
• Exploring the long-term impact of early life challenges for men who are suicidal	89	88	91	91	1	Accept
• Experiencing or witnessing psychological/emotional abuse	88	93	91	83	1	Accept
• Experiencing or witnessing physical/emotional neglect	88	92	93	85	1	Accept
• Family controlling behaviours, pressure and/or expectations	87	89	90	86	1	Accept
• Experiencing or witnessing physical abuse	83	84	88	80	1	Accept
• Death by suicide of a significant other	82	80	81	87	1	Accept
• Experiencing or witnessing sexual abuse	81	82	88	77	1	Accept
• Mental health problems in the caregiving home	80	85	76	81	1	Accept
• Caregiver absence, abandonment or estrangement	86	91	85	84	2	Accept

• Death of a significant other	85	81	79	91	2	Accept
• Investigating the impact of early life bullying and male suicide risk	82	81	70	85	2	Accept
• Addiction problems in the caregiving home	77	77	66	84	2	Reject
• Caregiver relationship conflict - including separation and/or divorce	74	79	81	68	2	Reject
• Growing up in poverty	71	66	72	74	2	Reject
• Caregiver(s) struggling with personal problems (e.g., financial, legal, emotional)	69	74	64	69	2	Reject
• Growing up with neuro-divergency (such as ADHD or Autism)	67	66	60	72	2	Reject
• Growing up with a disability / physical health challenges	66	72	60	67	2	Reject
• Sibling abuse	68	69	69	67	1	Reject
• Growing up in care	67	66	69	69	1	Reject
• Growing up as a minority (i.e., racial, sexual, trans, religious)	62	59	64	65	1	Reject
• Moving multiple times in childhood	44	45	45	44	1	Reject

Thematic Domain 6: Support and Recovery

• Exploring effective interventions for men who cannot afford / access therapy	93	92	94	96	1	Accept
• Exploring the experience of men who are suicidal of seeking professional support	93	91	94	96	1	Accept
• Exploring different intervention types	93	86	99	96	1	Accept
• Exploring the most effective long-term support for men who are suicidal	92	92	94	93	1	Accept
• Understanding what training healthcare professionals need to better identify and engage at-risk men	91	88	90	95	1	Accept
• Exploring the experience of men who are suicidal of seeking support from significant others	91	89	94	92	1	Accept
• Understanding how men cope after a suicide attempt	89	86	84	96	1	Accept
• Exploring what recovery means for men who have attempted suicide and men's reasons for living	88	84	84	96	1	Accept
• Exploring men's relationship with health-care professionals	87	84	87	91	1	Accept
• Exploring the experiences of significant others when supporting men who are suicidal	86	78	87	93	1	Accept
• Exploring the most effective support in the six months following a suicide attempt	85	88	81	88	1	Accept
• Exploring what professional support men who are suicidal want to receive	84	81	87	87	1	Accept

• Exploring how academic researchers and health care professionals can work together to incorporate research findings into services	84	75	87	90	1	Accept
• Exploring differences in how men and women present suicide risk and the best gender-sensitive screening tools for health services professionals	84	82	88	85	1	Accept
• Understanding how different services can work together better (i.e., how can the criminal justice system work with mental health care?)	84	75	87	90	1	Accept
• Exploring how to best measure the outcome of interventions, i.e., increased self-esteem and reduced suicide risk	84	82	87	84	1	Accept
• Exploring how to create communities that support men who are suicidal better	84	82	88	85	1	Accept
• Exploring the experiences of men who are suicidal of accessing support in their community	83	77	88	86	1	Accept
• Exploring effective training for community members to support men who are suicidal	80	76	76	88	1	Accept
• Exploring the experiences of community members who support men who are suicidal	85	83	77	92	2	Accept
• Exploring the experiences of health service professionals of working with men who are suicidal	83	77	83	88	2	Accept
• Exploring effective community members who can spot and engage at-risk men	80	72	72	89	2	Accept
• Exploring emergency admission and discharge	79	77	66	88	2	Reject
• Exploring effective community mental health role models for men who are suicidal	69	53	68	80	2	Reject

Thematic Domain 7: At-Risk Groups						
• Male survivors of abuse	90	92	94	89	1	Accept
• Middle-aged men	87	81	88	92	1	Accept
• Male university students	84	85	82	87	1	Accept
• Men with addiction problems	83	82	85	85	1	Accept
• Men bereaved by suicide	83	71	88	89	1	Accept
• Young boys (13 to 18)	82	82	85	82	1	Accept
• Men who are unemployed	81	85	84	78	1	Accept
• Men who are homeless	81	84	85	79	1	Accept
• Men living with multiple health conditions (e.g., physical and mental)	79	83	72	81	2	Reject
• Men aged 18 to 25	78	83	70	80	2	Reject
• Men in high-risk professions i.e., first responders, firefighters, police, paramedics	75	72	65	82	2	Reject
• Men military conscripts and veterans	74	66	81	74	2	Reject
• Men in the criminal justice system	73	79	74	69	2	Reject

• Men from lower income backgrounds	71	77	81	62	2	Reject
• Separated fathers	71	79	77	62	2	Reject
• Separated / Divorced / Widowed Men	70	74	72	65	2	Reject
• Men in insecure employment e.g., self-employed, zero-hour contracts.	69	68	70	69	2	Reject
• Sexual minority men (i.e., gay men, bisexual men)	67	68	68	67	1	Reject
• Men with disabilities	67	65	74	65	1	Reject
• Trans men	64	60	66	66	1	Reject
• Racial minority men	62	62	57	67	1	Reject
• Male immigrants, asylum seekers and refugees	61	58	63	64	1	Reject
• Indigenous men	58	54	57	63	1	Reject
• Men with autism	58	53	60	61	1	Reject
• Men with ADHD	58	53	64	58	1	Reject
• Men in rural communities	55	49	54	60	1	Reject
• Elderly men	55	54	56	57	1	Reject

• Men from traveller communities	45	38	44	51	1	Reject

Appendix 7.1 *Thesis recommendations for theoretical exploration*

Psychological Phenomenon	Recommendations
Pain	1. Explore theoretically disentangling psychological pain from physical pain to understand their specific relationship to suicide.
Culture	2. Explore integrating culture into theories of suicide and the impact of cultural norms on men's relationship with psychological phenomena identified as critical to suicide risk.
Emotions	3. Explore integrating emotional regulation into theories of suicide and how cultural norms impact how men learn to connect with and regulate their emotions and psychological pain e.g., what is the cultural ideal for male emotionality in a specific location? How are men culturally encouraged to regulate their emotions and cope with distress? Does living up to these behavioural standards enable men to regulate emotions in a manner orientated to long-term well-being or dysfunction?
Self	4. Explore the integration of feelings of failure in theories of suicide and how cultural norms of male success and social value impact men's relationship with self. e.g., what are the cultural ideals, expectations, and demands regarding what constitutes a man of social value and failure in specific locations? What are men culturally encouraged to do with feelings of failure? What are the cultural constrains to men's self-esteem, sense of agency, and competency?
Connections with Others	5. Explore how cultural norms impact on men's interpersonal needs, male loneliness and isolation, and how men build intimacy and meaningful connection. e.g., how do gender norms impact how men learn to build intimacy with others, the parameters for connection with friendships, family, and romantic dynamics?
Childhood Challenges	6. Explore theoretically integrating childhood challenges into theories of suicide and how they may impact men's exposure to, and tools to regulate, psychological pain, and how these processes may interact with cultural norms.
Evolution	7. Explore from an evolutionary perspective, why dysregulation of emotions, self, and connection with others might contribute to high psychological pain states and suicide risk. 8. Explore the cultural evolutionary context to psychological phenomena identified as critical to suicide risk.

Appendix 7.2 Thesis research recommendations

Target	Area	Recommendations
At-Risk Men	Relationship with Self	1. Investigate how men who are suicidal think and feel about themselves - *Including:* Exploring feelings of failure in men who are suicidal; Exploring the role of self-esteem, purpose and meaning, control and agency and self-reliance in male suicide risk/recovery; Understanding the best ways to support men who are suicidal to repair harmful thoughts and feelings about themselves
At-Risk Men	Relationship with Emotions	2. Investigate the emotional life and challenges of men who are suicidal - *Including:* Exploring the main sources of stress and emotional pain for men who are suicidal; Understanding how men understand, manage and express their emotions, who men talk to about their emotional problems, and the best way to support men to manage their emotions and emotional pain; Investigating trauma and male suicide risk; Surviving sexual abuse/assault
At-Risk Men	Suicidal behaviours	3. Investigate men's suicidal behaviours and coping strategies - *Including:* Exploring men's suicidal thoughts and feelings, how men manage thoughts of suicide and what prevents them from acting on them, what suicide means to men who are suicidal, what triggers a shift from thinking about suicide to planning a suicide, the thought patterns and emotional states of men when planning suicidal action, the past-thinking and future-thinking of men who are suicidal; Exploring the attitude of men who are suicidal towards seeking help and the experiences of men who are suicidal of seeking help; Exploring the coping strategies men who are suicidal use and male self-harm and suicide risk; Explore how to optimise reaching men before they become too distressed to seek support
At-Risk Men	Mental Health	4. Understand the mental health of men who are suicidal - *Including:* Investigating the relationship between having a mental health condition and male suicide risk; Exploring which mental health conditions are most relevant to male suicide; Exploring what language and messages are best to engage men who are suicidal around mental health issues and how men's mental health and suicide are represented in society and how these ideas impact men who are suicidal
At-Risk Men	Relationships with Others	5. Investigate loneliness and isolation for men who are suicidal 6. Investigate the role of meaningful interpersonal connection and intimacy in male suicide risk and recovery - *Including:* Exploring what meaningful connection means to men who are suicidal; how men build connections; challenges men experience creating connections; the best ways to support men to create/sustain meaningful connection; how meaningful connections can protect men from suicide 7. Investigate interpersonal challenges and male suicide - *Including:* Domestic abuse (physical, sexual, emotional, and/ or psychological); romantic break ups; and interpersonal conflict
At-Risk Men	Early Life Experiences	8. Explore the long-term impact of early life challenges for men who are suicidal 9. Understand the mental health of young boys who are suicidal *Including:* Exploring how mental health problems - including suicidal thoughts, feelings and attempts - develop in young men, exploring how young men seek help (i.e., talking to teachers, peers, medical professionals, chat rooms) and cope with their problems and exploring the best ways to support young men who are suicidal 10. Understand early-life abuse/trauma and male suicide *Including:* Experiencing or witnessing psychological/emotional abuse, physical/emotional neglect, physical abuse, and sexual abuse, death by suicide of a significant other, death of a significant other, early life bullying, family controlling behaviours, pressure and/or expectations, mental health problems in the caregiving home, caregiver absence, abandonment or estrangement
At-Risk Men	Structural Factors	11. Investigating the role of work in male suicide risk and recovery - *Including:* Exploring the role of work stress and unemployment in male suicide risk; Understanding the importance of work as providing meaning, fulfilment and identity for men who are suicidal 12. Investigating financial challenges and male suicide risk - *Including:* Exploring financial pressures and debt**,** poverty, insecure housing/homelessness 13. Investigating the combined impact of multiple-structural challenges and male suicide risk i.e., being unemployed, having a disability and living in insecure housing
At-Risk Men	Cultural Factors	14. Investigating the role of masculine norms in male suicide risk and recovery - *Including:* Exploring gender differences in how distress is expressed, understood, and responded to by people; Exploring how men who are suicidal develop and form their ideas of masculinity

At-Risk Men	At-Risk Groups	15. Explore men experiencing life transitions - *Including:* Young boys - 13 to 18, Male university students, Middle-aged men 16. Explore men experiencing structural challenges - *Including:* Men who are unemployed; Men who are homeless 17. Explore men experiencing emotional challenges - *Including:* Male survivors of abuse; Men bereaved by suicide, Men with addiction problems
At-Risk Men	Understanding the psychobiology of psychological pain	18. Explore potential biomarkers that could indicate heightened psychological distress that could be assessed clinically 19. Explore the relationship between psychological pain and factors such as diet, inflammation, brain-gut axis, sleep patterns, stress regulation, memory and cognition patterns, neural and neuroendocrine activity, immune factors, and nervous system regulation 20. Explore potential differences in the role of psychological pain and physical pain on suicide risk
At-Risk Men	Recovery	21. Explore what 'recovery' means for men who are suicidal - *Including:* Understanding how men cope after a suicide attempt, what recovery means for men who have attempted suicide, and men's reasons for living 22. Explore effective interventions *Including:* Exploring the most effective support for men in the six months following a suicide attempt and the most effective long-term support; Exploring the impact of different intervention types (including universal, selected, and indicated interventions, and different intervention types such as talk therapy, medication, media campaigns); Exploring how to best measure the outcome of interventions, i.e., increased self-esteem and reduced suicide risk
Services	Health Professionals	23. Explore the role of health-care professionals in supporting men who are suicidal, *Including:* Exploring men's relationship with health-care professionals and the experiences of health service professionals of working with men who are suicidal ; Exploring the experience of men who are suicidal of seeking professional support and what professional support men who are suicidal want to receive; Understanding what training healthcare professionals need to better identify and engage at-risk men; Exploring differences in how men and women present suicide risk and the best gender-sensitive screening tools for health services professionals; Exploring how academic researchers and health care professionals can work together to incorporate research findings into services 24. Explore training for professionals in male gender, male psychology, and male suicide risk and recovery factors 25. Explore tools to help professionals address their own gender bias and increase positive understandings of masculinity
Services	Clinical Assessment	26. Explore moving away from risk assessment and towards developing potential risk profiles built on potential risk markers relating to denial, disconnection, and dysregulation in self, emotions, interpersonal connections, and psychological pain.
Services	Service Design	27. Explore men's emergency admission and discharge experiences 28. Explore designing services and delivery systems in collaboration with lived experience experts 29. Explore tailored interventions for men that potentially utilise masculine norms such as strength, self-reliance, and autonomy 30. Explore effective interventions for men who cannot access/afford services, including services outside working hours 31. Explore digital psychoeducation programmes and tools for managing suicidal behaviours 32. Understanding how different services can work together better (i.e., how can the criminal justice system work with mental health care?) and multi-agency interventions i.e., structural support as well as psychological 33. Explore interventions to strengthen men's psychological capabilities
Services	Therapy	34. Explore psychological interventions which target helping men to: 1) regulate psychological pain, 2) regulate emotions, 3) revise aversive concepts of self, especially with regards to feelings of masculine failure and shame, and 4) improve interpersonal relating and meaningful connection
Community	Community Support	35. Exploring community interventions - *Including:* Exploring how to create communities that support men who are suicidal better; Exploring the experiences of men who are suicidal of accessing support in their community and the experiences of community members who support men who are suicidal; Exploring effective community members who can spot and engage at-risk men and effective training for community members to support men who are suicidal 36. Explore volunteering opportunities for men who are suicidal
Significant Others	Significant Others	37. Explore the role of significant others in supporting men who are suicidal *Including:* Exploring the experiences of men who are suicidal of seeking support from significant others and the experiences of significant others when supporting men who are suicidal 38. Explore how suicide disclosures are communicated, received, and responded to; Explore how significant others could be upskilled to respond effectively whilst protecting their own wellbeing 39. Explore mental health challenges for carers of men who are suicidal and potential support to help them cope with long term suicidal crises

		40. Explore psychoeducation for significant others on male suicide risk and recovery factors 41. Explore working therapeutically with families' post-attempt 42. Explore how the 'insider' knowledge that significant others can provide on a man's state of mind may be utilised by mental health professionals to keep men safe whilst respecting a man's dignity and autonomy
Population	Public Health Messaging	43. Explore social representations of the biomedical model of mental illness and suicide and how these may impact men's sense-making of their suicidal pain and coping/help-seeking behaviours 44. Explore how men understand the causes of their suicidal behaviour and how these ideas could be integrated into public health campaigns 45. Avoid campaigns that characterise men as reluctant/poor help-seekers or as emotionally impaired 46. Explore campaigns to challenge population-level stigma around men seeking help 47. Explore high-profile men normalising seeking help 48. Explore campaigns to address potential lag between old norms of male help-seeking (i.e., emotional stoicism and suppression) and new norms of male help-seeking (i.e., talking and seeking support) 49. Explore the most effective messages to increase men's perceptions of the benefits of seeking support 50. Explore campaigns to help men understand different help-seeking pathways and therapeutic modalities 51. Explore campaigns to normalise a lack of psychological capability and problematise male emotional socialisation rather than personal inadequacy 52. Explore campaigns to reclaim the centrality of emotions and emotional regulation in the male psyche 53. Explore campaigns that position men as legitimate candidates for care and support 54. Explore campaigns that more accurately reflect the reality of help-seeking journeys within the current resources of mental health systems
Population	Psychoeducation	55. Explore psychoeducation programmes that can help support people to better regulate emotions, selfhood, interpersonal connections, and psychological pain 56. Explore early-life psychoeducation to build psychological capability around help-seeking 57. Explore psychoeducation programs and campaigns to help lay people better understand male gender, male psychology, and male suicide risk and recovery factors 58. Explore psychoeducation programs to provide people with tools to ask about suicide and respond to suicide disclosures
Population	Cultural Representations of Masculinity	59. Explore how all genders may perpetuate masculine norms 60. Explore richer representations of masculinity in the public domain especially around honouring male emotionality, expansive male selfhoods, male interpersonal needs, normalising struggles, and highlighting potentially counterproductive coping strategies

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