Reconstructing responses following communications of intent to suicide: What role do gender norms play?

A sociological autopsy

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Summary

Men who suicide outnumber women 3:1 yet women exhibit more suicidal behaviours than men, a phenomenon known as ‘the gender paradox’. Previous studies have explained this paradox as a consequence of suicide method choices between men and women, but these explanations may not be sufficient, we examine whether responses to communications of intent to suicide may also affect the gender paradox.

This thesis aims to answer: what role do gender norms play in responses to communications of intent to suicide? A mixed-method (quantitative and qualitative) ‘sociological autopsy’ was performed on 175 cases of people who made a communication of intent before they died by suicide in Queensland during 2014. Communications made to both lay people (such as friends and partners) and/or organisations (such as police or mental health professionals) were examined.

Quantitative results indicate that not only may gender norms play a role in responses to communications of intent, but also how they communications are made and who they are made to. The qualitative analysis includes reconstructed case types, drawn from multiple cases of suicide and show that masculinities (violent, subordinate, and rational) played a major role in how people, particularly (female) partners, responded to communications of intent made by suicidal men. The gender paradox may, to some extent, also be explained by how suicidal men engage with their social spheres when they communicate intent to suicide and in turn, how these people respond.

Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Ethics approved by:

- *Macquarie University's Human Research Ethics Committee (HREC) Humanities and Social Sciences (HASS), reference number 5201834315018;*
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Chapter One
Introduction

Every three hours, someone in Australia dies by suicide (ABS, 2018). Though the ratio of male to female suicides is 3:1 (ABS, 2019b), women are more likely than men[1] to exhibit suicidal behaviours, such as non-fatal suicide[2] and suicidal ideation (AIHW, 2014; AIHW, 2018), a phenomenon known as 'the gender paradox of suicide' (Canetto and Sakinofsky, 1998; Rugkhla, 2011). Gender has long been known to play a role in suicidal behaviours in both men and women (Jaworski, 2003; Jaworski, 2010; Scourfield, 2005). Scholars have linked notions of masculinity, such as stoicism, with emotional distress and a reason for the higher suicide rate in men (see Canetto and Cleary, 2012; Cleary, 2005; Kunde et al., 2018; McPhedran and De Leo, 2013; Milner et al., 2017; Perceval et al., 2018; Player et al., 2015; Scourfield, 2005; Scourfield and Evans, 2015; Scourfield et al., 2012; Shiner et al., 2009). Up to half of those who die by suicide communicated their intent in some way (Isometsä, 2001; Pompili et al., 2016). Despite communications of intent made before death being a well-known suicide prevention opportunity, there is little research into how particular groups of people (professional and lay) responded to these communications and the role of gender norms in their responses (Pompili et al., 2016).

The overall goal of this thesis is to understand what role gender dynamics play in responses to communications of intent using the sociological autopsy method in an effort to broaden understandings of why men suicide more frequently than women. In this analysis, the role of masculinity will be focused upon through a pragmatic approach to the question 'what role do gender norms play in responses to communication of intent?' by including both a quantitative and qualitative study of closed-case suicides identified from the National Coronial

[1] Though it is well known that there are many types of gender, this thesis refers only to 'men' and 'women' as they are coded on the National Coronial Information System (NCIS), which uses dichotomised labelling based on the documentation provided to them.

[2] There is conscious use of the term 'non-fatal suicide' throughout this thesis to shift away from conceptualisations of suicidal behaviour that results in a death as "complete" or "successful" while suicidal behaviours that are survived as "unsuccessful" "attempts". This use of language is an effort to eliminate the dichotomy of suicide as something that must result in death, which hides the widespread suicidal behaviours of men and especially women, who experience and survive suicidality and represents a death by suicide as a desired 'successful' outcome. For further information on gendered language and suicide see Canetto and Lester (1998).

Information System (NCIS)[3]. Quantitative analysis will compare who, how, and when men and women communicated intent to suicide and the responses taken by people known to the person who died or by the service system. The qualitative analysis examines the performances of masculinities in responses to communications of intent. This thesis will answer the following questions:

1. Are there differences in the demographic and psychosocial backgrounds, previous suicidal behaviours, and communications of intent (mode, recipient, timeframe, directness, and level of response) between
    a. men and women who died by suicide;
    b. men who received an intervention or were dismissed following their communication of intent and;
    c. men who received organisational-level and lay-level interventions?
2. What role do gender norms play in how communications of intent were responded to, focusing on masculinities?

This thesis does <u>not</u> *aim to explain why people suicide or the suicide rate* but rather the role of gender *in responses to communications of intent* before a suicide, with a view to improving responses to communications of intent and the outcomes of scenarios in which formal services are required. We look at the role gender plays in the quality and types of response. We are curious about whether men are more likely to be dismissed (that is, receive no intervention) than women following a communication of intent to suicide which might explain the overall higher rates of women being hospitalised and accessing mental health services than men (AIHW, 2018) and the role gender norms play within these outcomes. The underlying assumption should not be that if recipients of communications of intent had responded in a different way, each suicide could have been prevented or that the recipients were responsible for what happened. Rather, this thesis attempts to identify systemic patterns of responses to communications of intent.

It is social interactions that are of interest in this study. We focus on how the social meanings expressed through gendered behaviours by the suicidal person interact with the response to the communication of intent. The goal is to provide information into how communications of

[3] The NCIS is managed by the Victorian Department of Justice and Community Safety and is an online database of all coronial information in Australia since 2000 and includes coronial findings, police, and pathology and autopsy reports post-mortem reports from all deaths by intentional self-harm (NCIS, 2018).

intent are responded to as well as inform service responses and policy in how health services are utilised (or not) and why, with an overall aim to prevent future suicides. This thesis draws on the NCIS to identify a pool of cases for in-depth qualitative analysis of gender dynamics in communications of intent. The chapters are as follows:

Chapter Two examines literature from sociology and suicidology and provides the theoretical background for this study. Four main contributions to the sociological understanding of suicide are examined, Emile Durkheim's integration theory, Jack Douglas' *The Social Meanings of Suicide*, J. Maxwell Atkinson's book *Discovering Suicide*, and Fincham et. al.'s work *Understanding Suicide*, these works provide a critical framework for reflection and analysis of suicide data – the sociological autopsy method. The chapter then canvasses and analyses how the gender paradox has affected research into suicide and then reviews literature on communications of intent, with a specific analytical focus on gender.

Chapter Three builds upon the theoretical background covered in Chapter Two and discusses the methodology and methods used in this thesis. The methodology outlines the use of coronial case files and provides some precautions that must be acknowledged in this type of analysis. The chapter then provides an overview of the two key methodologies used in this thesis; the quantitative analysis of coronial case files (procedure, variables used, and analysis) and the qualitative analysis. The qualitative analysis includes an innovative method used in this thesis which is the creation of reconstructed case types. These case types draw upon scenarios which encapsulate key aspects of themes, as identified through thematic analysis of masculinities, within cases of suicide by men.

Chapter Four outlines the findings in two sections. The first section reports the results of the quantitative phase of this thesis and is followed by a brief analytical discussion of the results including differences in how and to whom communications of intent were made, and the responses received. The second section reports the qualitative analysis and outlines how themes of violent, subordinate, and rational masculinities play a role in responses to communications of intent.

Chapter Five provides an analytical discussion of both sections of results and a conclusion to the thesis where we explore the implications of gender dynamics and expressions of masculinities in how communications of intent were responded to, and why it may be that

men die more frequently of suicide than women. This section also includes limitations of this thesis and future avenues for research.

Chapter Two
Literature Review

The goal of this chapter is to provide a background into current understandings of gender, suicide, and responses to communications of intent. The first section provides an overview of the key sociological understandings of suicide that inform the analysis in this thesis. The literature review, which follows the theoretical background, has two aims: 1. to introduce the gender paradox and review its effects on suicide research; and 2. to apply a gendered focus and review previous research into communications of intent to suicide. Ultimately, this chapter establishes a) the relevance of suicide theory for critical reflection of coronial data, b) the role of gender in suicide, and c) the role of gender, especially forms of masculinity, in understanding responses to communications of intent.

Sociological approaches to researching suicide

The sociological study of suicide transformed since Durkheim's ([1897]1951) *On Suicide.* Three further major contributions have been made to our current understanding of suicide; Douglas (1967) provided a crucial critique to Durkheim's approach in his book the *Social Meanings of Suicide,* Atkinson's (1978) *Discovering Suicide* applied the insights from Douglas' work to understand coronial decision making*,* and finally contemporary sociologists Ben Fincham, Susanne Langer, Jonathon Scourfield, and Michael Shiner's (2011) book *Understanding Suicide,* which draws upon the three previous works and outlines the sociological autopsy method used in this thesis. These works will be presented in chronological order to illustrate the sociological autopsy method and why this approach is relevant to understanding gender in cases of suicide.

Durkheim

Sociology and suicide have a long history. Emile Durkheim, a founding father of sociology, argued that to understand why suicide rates vary from country to country, sociologists needed to look beyond the suicidal individual and instead, understand them within their larger social context (Durkheim, [1897]1951). He argued that an individual's mental state at the time of suicide is not the domain of sociologists and should be left to psychology. Instead, Durkheim

reviewed and compared large-scale data sets of international suicide rates, and other socio-cultural statistics, such as marriage and divorce rates, in order to explain patterns among them.

Durkheim's central thesis was that society is made up of a complicated web of interactions between individuals, and each interaction serves a specific function that is needed or wanted by others in society (Durkheim, [1893]1969). He argued that as societies become more complex, the division of labour becomes specialised (Durkheim, [1893]1969). This creates complex relationships of interdependency within society, which Durkheim describes as 'organic solidarity' (Durkheim, [1893]1969:56).

Striking the balance between specialisation and the needs of society is paramount to the functionality of the individual-society reciprocal bond (Durkheim, [1893]1969:171). Durkheim called this interdependent relationship 'integration'. Alongside integration is the degree of 'regulation' which refers to the level people are constrained by their social circumstances (Durkheim, [1897]1951; Durkheim, [1893]1969). Durkheim hypothesised that a disturbance to integration and regulation explains suicide rates. Changes within the political, environmental, cultural, and social climates impact individuals and the suicide rates in varying ways, as well as smaller micro-interactions that might appear on the large scale. For example, an increase in divorce rates, due to a cultural shift in the meaning of marriage, may also increase or decrease suicide rates. Therefore, Durkheim positioned suicide as a social issue with a social cause and broadened understandings of suicide from an individualised, psycho-pathological illness.

Douglas

Jack Douglas' book *The Social Meanings of Suicide* (1967) is in large part a critique of Durkheim's methodology in *On Suicide.* Douglas critiqued Durkheim's positivist approach, in that Durkheim did not take into consideration the vast cultural differences in understanding and reporting suicide (Douglas, 1967:165-166). Douglas argued that to understand suicide rates, we also need to understand the processes that create them because suicide rates are social artefacts. A suicide rate is not an empirical phenomenon, but a human construction, built on a series of culturally informed understandings of what suicide is. To assume a suicide is a clear-cut action, as Douglas accused Durkheim of doing, is to overlook the cultural shifts

in the meanings and understandings of suicide, not only between cultures and countries, but also over time (Douglas, 1967).

The process of creating suicide statistics, Douglas (1967) asserted, is largely reliant on lay informants, usually people known to the deceased, the statements of whom are provided to police and inform a coroner's decision on whether there was a suicide. That *decision* is counted by statisticians and informs the suicide rate. Therefore, who is asked to give evidence about a person after their death may affect whether the death is determined to be a suicide (Douglas, 1967:185-188). Douglas contended that the heavy reliance on lay informants highlights the need for sociologists to understand the social meanings of suicide within the context in which they occur. Douglas argued that sociologists are in a unique position to identify and explain these shifts because they can adopt an etic perspective on the society in which they live and understand it as 'cultural insiders' (Douglas, 1967:266-270).

Finally, Douglas argued that in order to fully realise the sociologist's ability to interpret the social meanings of suicide, we must "weave back and forth between the general and the particular" (Douglas 1967:270). According to Douglas, Durkheim's dismissal of individual perspectives in favour of large-scale patterns lost valuable insights into why people suicide (Douglas, 1967:265-270). The use of case studies, Douglas argued, would help gain these lost insights into how a suicide is identified, understood, and constructed within its social context. Through case studies, sociologists can 'weave' between wider social processes and their effects on individuals, identify fluctuations in these processes, and identify large-scale patterns. Douglas, therefore, set out a new paradigm to drive a sociological understanding of suicide which critically analyses and interprets the meaning and construction of suicide within society.

Atkinson

In *Discovering Suicide*, Atkinson (1978) also critiqued Durkheim's positivism and concurred with Douglas' argument for the individual's perspective to understand suicide. However, he critiqued Douglas for not providing a concrete method to decipher the social meanings of suicide[4]. Atkinson was critical of the approach by sociologists' analyses of suicide 'from a

[4] This was not Douglas' aim, rather, Douglas set out to provide a framework for how to understand the construction of suicide statistics.

distance' (1978:9). Instead, he took an ethnomethodological approach to the coronial decision-making process and its effects on overall suicide rates. His approach instead involved discussing the decision-making process with coronial staff and coroners through an in-depth qualitative analysis.

Atkinson concluded that the coronial process is characterised by a complex, context-based analysis of evidence within the parameters of socially constructed common-sense theories, resulting in a feedback loop between coroners, the media, suicidologists, and lay people, who provide evidence of suicide that in turn provides evidence for the coroner (Atkinson, 1978:145). To decide whether a suicide occurred, the coroner takes each piece of evidence and creates a story of suicide. Atkinson uses the example of suicide notes to illustrate this process. One piece of evidence alone is not enough to rule a suicide, instead, the coroner relies on interpretations of collections of evidence in order to make their decision (Atkinson, 1978:117-123). Atkinson contributed the overall understanding of sociology and suicide research by applying Douglas' social meanings of suicide theory and critically reflecting on the coronial process of suicide.

Fincham, Langer, Scourfield, and Shiner (Fincham, et al. 2011)

Atkinson (1978:9) acknowledged that the sociological interest in suicide since Durkheim has been lacklustre. Through the use of the sociological autopsy method, Fincham et al. (2011) aimed to 're-engage' and 'reinvigorate' the sociological study of suicide (2011:7). Fincham et al. (2011) aimed to connect the methodological differences between Durkheim, Douglas, and Atkinson, by designing a 'sociological autopsy' approach to understanding suicide, which integrates quantitative and qualitative data. They do this by critically reflecting upon the social meanings of the data used in coronial case files, as proposed by Douglas and Atkinson, in order to find generalisable patterns, as proposed by Durkheim.

Their application of the sociological autopsy method to 100 cases of suicide, indicated a correlation between cases with the "socially structured life-course" particularly among the middle-aged (Fincham et al., 2011:135). For example, the authors found that threats to gendered expectations of middle-aged men to be 'providers' was a common reason for suicide among this group (Fincham et al., 2011:155). The sociological autopsy approach is a uniquely sociological interpretation of suicidal behaviours, usually associated with

psychological and psychiatric research. *Understanding Suicide* is a framework for renewing the sociological interest in suicide and providing a methodology for combining often opposing quantitative and qualitative methods.

The implications for this thesis from Durkheim's theory of integration is that social forces, such as gender, play a part in why people suicide. Douglas provided an analytical framework in which to critically reflect on how suicide is understood and constructed within coronial files. The use of case studies that weave between the general and the particular are also used in the case type section of this thesis. Atkinson draws from Douglas' insights that suicide statistics are a social artefact, to bring the analysis back to the coronial process itself and how these processes are also critical in deciding whether a suicide occurred or not, thus opening up a critical perspective on the use of data derived from coronial processes. Finally, the importance of Fincham et al. is their contribution to the sociological autopsy methodology used in this thesis. However, with the exception of Fincham et al., gender remains a muted category within sociological suicidology, particularly how people and services respond to different experiences of gender. We now turn to reviewing research on gender and suicide.

Research on gender and suicide

Defining gender

Gender is a social structure (Ridgeway, 2009; Risman, 2009). It is a concept created (and recreated) within society and made *by people.* Therefore, there is no 'natural' way to 'be' 'gendered' it is a human-conceived concept. To understand gender as a social structure is to cast it as a means by which societies order and classify behaviours to navigate interactions with individuals and groups (Risman, 2004). Gender is also, therefore, often described as something which is 'done' (West and Zimmerman, 1987). However, as Ridgeway (2009) argues, gender as a social structure means it is more complex than simply 'doing' or 'performing' prescribed behaviours for men and women, it is a frame of reference for interactions. This frame of reference is used to create a social cooperation and anticipate how interactions will play out, depending on the context in which they occur.

It is within these various contexts that variations within masculinity and femininity occur, or as Connell (2005) labelled: masculinit*ies* and femininit*ies.* The context in which interactions occur affects the extent to which gender norms play a role and the types of gender norms

utilised by each actor. However, Risman (2009:83) reminds us that people do not simply 'do' gender and are not 'determined' by social expectations of femininity and masculinity. Men and women do actively reshape and rethink how they want to behave and indeed 'undo' gender. This is not to deter from the types of ways of being masculine or feminine, but to remind that masculinities and femininities do not exist simply because men or women *do something* (Risman, 2009:82-83), which leads to essentialist understandings of gender. In her critique of interpretations of gender differences in suicidology, Canetto (1997a) argues that future suicide research with a focus on gendered suicidality must encompass a blend of both understanding how gender is used collectively and also the effects of individuality. It is within these tensions between how men and women feel they *ought* to relate to one another in specific contexts and what they actually *do* during and after a communication of intent to suicide that is of primary interest to this thesis and is explored further in the qualitative section.

The gender paradox of suicide

Suicide is a deeply gendered phenomenon, enacted within culturally bound and socially transmitted behaviours (Beautrais, 2003; Canetto, 1991; Canetto, 1997b; Canetto, 2008; Canetto and Cleary, 2012; Canetto and Lester, 1998; Canetto and Sakinofsky, 1998; Jaworski, 2003; Jaworski, 2010; Scourfield, 2005). 'The gender paradox of suicide' is a term coined by Canetto and Sakinofsky (1998) to identify a long observed phenomenon: that though women exhibit more suicidal behaviours than men, more men die by suicide. Canetto and Sakinofsky (1998) dismantled claims from previous suicidologists that the gender paradox is an error from flawed data collection and/or incorrect interpretations of suicide statistics. They conclude that the gender paradox is a result of 'cultural scripts' which reify expected masculine and feminine performances of distress along gender binaries.

Gendered cultural scripts not only construct the gender paradox of suicide, but also reinforce social meanings of suicide through a gendered binary. This binary is described by Canetto and Lester (1998): that suicide is considered a masculine behaviour, while non-fatal suicidal behaviour is associated with femininity. For men in the United States, Canetto and Sakinofsky (1998) argue, the act of suicide is viewed as heroic, a means of exerting agency in the face of uncontrollable circumstances. Non-fatal suicidal behaviours are feminised, and viewed as the opposite: as passive, attention-seeking behaviours (Canetto and Sakinofsky,

1998:17). The gender paradox is explained by socially prescribed gendered behaviours that expect a male suicide to be fatal, lest he become feminised and emasculated by surviving. Men, therefore, often tend to choose more 'lethal' means to suicide, while women are more likely to have access to medications that can become an overdose (Kanchan and Menezes, 2009), a less lethal means due to its longer window for intervention. Surviving a suicide, therefore, is a feminised performance of distress.

Jaworski (2003; 2010), draws upon Butler's theory of gender performativity to explain how differences in suicidal behaviours (or 'cultural scripts') manifest, which in turn contribute to the gender paradox. Her arguments are a critique of the assumed procedural nature of suicide, that it can be neutrally and scientifically understood through unbiased investigation of the body and life circumstances. Interpreting a corpse in this way, sustains an environment of empiricism and positivism, without questioning why gendered differences in suicide occur, a parallel we have seen in the work of Douglas and Atkinson. Gender performativity is a process of constantly 'doing' gender through a series of learned behaviours, which over time, may start to feel innate, giving the impression that differences between men and women are 'natural' (Jaworski, 2010). Jaworski describes these behaviours as 'citational', and Butler refers to them as 'iterability' (Butler, 1993). Suicidal behaviours are also ingrained within these gendered expectations. Every aspect of a suicide, from the decision to die, to the investigation and interpretation of the death is gendered (Jaworski, 2010). Jaworski (2003; 2010) argued, that the overlooked and unquestioned role of gender in suicide investigations precipitates and maintains an understanding of suicide in sex-binary opposites.

These assumptions of gendered behaviours as naturally different and the subsequently hidden sex-binary suppositions, have far reaching effects, including within suicide research. An example of how the gender binary creeps into suicide research is exemplified in a paper by Denning et al. (2000). The authors interviewed people within the close social circles of 141 people who died by suicide, 20% of whom were women. Their aim was to "test whether women who commit suicide use less violent means because they are less intent on dying" (Denning et al., 2000:282). Their results showed that two thirds of men chose violent means and half the women chose non-violent means of suicide. They found no variation in intention to die between genders. Denning et al.'s (2000) conclusion and discussion only explored why women chose less violent means and ignore their own results that *half* the women chose violent means and a third of men chose non-violent means. The focus on differences between

genders in suicide research is an example of how gender orders are reproduced through research (Butler, 2006), which subtly reinforces the idea that men and women are innately different, even when the authors' evidence does not support this conclusion.

A further implication of the gender paradox, and its presumed sex-differences is that men and women are frequently categorised as not only distinct, but respectively homogenous. Understanding gender through binary oppositions has led to an essentialist understanding of male and female suicides as not only distinct from each other, but also has erased the variation of experiences within the groups (Scourfield, 2005). In his critique of the representation of gender within suicidology, Scourfield draws on Connell's theory of multiple masculinities, which identifies and analyses the diversity within how men experience and engage with masculinity (Connell, 1987; Connell, 2005; Scourfield, 2005). Scourfield asserts that gender is a multi-dimensional spectrum. Where a person falls on that spectrum is dependent on a multitude of variables. For example, a man may have context and role-specific experiences of masculinities because social expectations of masculinity change when a man is embodying various roles like father or husband, and these expectations may change with age, or cultural background. To label 'men' and 'women' without regard for masculinities and femininities overlooks potentially vital explanations of suicide.

Furthermore, gendered behaviours of suicide are reinforced and maintained by social expectations of performances of distress by men and women (Canetto and Lester, 1998). The citational nature of gendered suicide methods are hypothesised to have contributed to the gender paradox of suicide. Beautrais (2003) confirmed this theory by testing suicide outcomes between people who died by suicide, medically serious non-fatal suicides, and a control group. She concluded that the gender paradox is explained by method choice and "that if women were to adopt more lethal methods, then the female suicide rate may approach or even exceed the male suicide rate" (Beautrais, 2003:1097). At the time of Beautrais' study, the most common suicide method choice for women was poisoning (AIHW, 2014). Since then, the more lethal means of hanging has become the most common suicide method choice for women (AIHW, 2014; ABS, 2019a). Despite the changes in choices of methods by women, rates for female suicide and hospitalisations for self-harm and suicide have remained relatively stable over the past 30 years (ABS, 2019b; AIHW, 2018).

To understand men and women as binary, homogenised groups is to overlook the similarities between, and differences within, genders and suicidal behaviours. A new approach, which critiques taken for granted notions of gender differences, is needed. This thesis aims to broaden the focus of explanations for the gender paradox from just suicide method choice. We examine instead what Canetto and Sakinofsky (1998:19) concluded contributes to the gender paradox: *cultural expectations about gender and suicidal behaviour*. We do this through an analysis of 'gender scripts' and their roles in responses to communications of intent to suicide, rather than method choices. We now turn to examine the literature on communications of intent.

Communications of intent to suicide: recipients and responses

On average, almost half of people who die by suicide communicate their intent in some way (Pompili et al., 2016). Communications of intent to suicide have been described as one of the most important risk factors to suicide as well as an opportune time for intervention (McPhedran and De Leo, 2013). Despite over 60 years of research into communications of intent, the body of literature is sparse: only 36 articles were identified in a meta review by Pompili et al. completed in 2015, with very few articles investigating how communications of intent were responded to (Pompili et al., 2016).

Most literature that investigated responses to communications of intent to suicide, tended to focus on how the communication was interpreted by respondents at the time of the event (see Fu et al., 2013; Kjølseth and Ekeberg, 2012; Orbach et al., 2007; Owen et al., 2012; Owens et al., 2011; Rasmussen et al., 2014; Robins et al., 1959; Rudestam, 1971; Westerlund et al., 2015; Wolk-Wasserman, 1986). Overall, studies investigating responses to communications of intent interviewed participants who were close to someone who died by suicide, possibly resulting in an over representation of communications and responses made to lay people[5] (Pompili et al., 2016). Despite this possible over-representation, these studies provide valuable insights into what occurs during a communication of intent.

Uncertainty about what to do has persistently been a common theme throughout literature investigating responses since Robins et al. (1959) pioneered investigations into

[5] In this study the term lay people will be used as a shorthand category for people known to the suicidal person and who was not in a service role. This includes family members, intimate partners, and friends.

communications of intent. Disbelief in the veracity of the communication of intent, or an inability to correctly decipher the meanings and gravity of the communication was common and affected how people responded (Kjølseth and Ekeberg, 2012; Orbach et al., 2007; Owen et al., 2012; Rasmussen et al., 2014; Robins et al., 1959; Rudestam, 1971). Participants in the studies also described feelings of anger and resentment towards people who frequently talked about suicide, oftentimes resulting in no response due to a general sense of being overwhelmed and exhausted by the constant worry (Kjølseth and Ekeberg, 2012; Robins et al., 1959). Owens et al. (2011) discuss the complex and high-risk decision-making friends and family members make throughout the process of responding to a communication of intent. They describe a common fear of "doing the wrong thing" and potentially damaging their relationship with the suicidal person (Owens et al., 2011:6). These sentiments were echoed by close friends and family members of suicidal men in a study by Player et al. (2015:6-7).

Though many recipients of communications of intent responded in some way, few engaged help from health services. Orbach et al. (2007) and Rasmussen et al. (2014) provide some insight into why this may have been. Many of the soldiers in Orbach et al.'s study (2007) did not engage a mental health professional after a colleague made a communication of intent to suicide because they felt that the emotional support they provided appeared to help and that the reasons the soldiers gave for their suicidality, for example, a relationship breakdown, could not be repaired by a mental health professional. Rasmussen et al. (2014) also found that many of their male informants were concerned that putting pressure on the suicidal man to see a mental health professional would "put additional strain on the deceased's self-esteem" (Rasmussen et al., 2014:1631), indicating an overall fear of exacerbating the distress of the suicidal person.

When recipients of communications of intent took the suicidal person to hospital, their situation was summed up by Robins et al. (1959:733) as "left with an insoluble problem" due to the perceived inadequacy of suicide assessment processes and treatment in hospitals. Negative experiences of suicidal people in contact with health professionals has been widely reported (Bleeser et al., 2010; C.R.E.S.P, 2015; De Leo et al., 2005; Fletcher, 1999; Hengeveld et al., 1988; Hill et al., 2017; Player et al., 2015; Samuelsson et al., 2000; Strike et al., 2006; Taylor et al., 2009). Hospital staff were often identified as a problematic aspect of help-seeking during a suicide crisis. Studies of clinical staff who treat patients that exhibit

self-harm and suicidal behaviours found their attitudes towards patients to be overwhelmingly negative (Saunders et al., 2012), with some staff labelling suicidal patients as malingerers (Hopkins, 2002). Suicidal patients have also reported a feeling of being burdensome due to attitudes of hospital staff toward them (Samuelsson et al., 2000). These studies demonstrate that negative experiences with health providers has shaken the confidence of suicidal people and their support networks, potentially hampering use of health services during future suicide crises (Bleeser et al., 2010; Cottrell, 2013; C.R.E.S.P, 2015; De Leo et al., 2005; Strike et al., 2006).

Communications of intent and gender

Notably absent from this literature is a gendered interpretation of results. Though gender appeared to play a part in some studies, it was not specifically discussed. For example, the male recipients of communications of intent in the study by Rasmussen et al. (2014) were concerned for the suicidal man's self-esteem if he felt pressured to see a mental health professional. Such a response seems in line with commonly held beliefs of men being 'the stronger sex' (Courtenay, 2000), pointing to a potential conflation of masculinity with self-esteem. Rudestam (1971:89) briefly provided a gendered perspective regarding why women in his study were taken more seriously following a communication of intent, hypothesising that "direct suicidal verbalisations may have been inconsistent with the male role" (Rudestam, 1971:89), however, with no link to gender theory it is difficult to decipher what specifically he means by the "male role". McPhedran and De Leo (2013) use gendered expectations of stoic 'traditional' masculinity to set up their hypothesis that suicidal rural men would be less likely to communicate intent to health professionals than suicidal urban men, yet they do not apply a gendered understanding to their results. There is a need for an informed gendered perspective on how communications of intent unfold, and the responses taken if we want to understand why men die more frequently of suicide than women.

Conclusion

Assumptions regarding gender differences, without consideration of a gendered perspective, have been consistent in suicide research and have recently come under critique. This chapter has demonstrated the application of gender theories, which explain the socially constructed nature of suicide, as theorised by Jaworski (2003) and Scourfield (2005), is the forefront of

current understandings of the gender paradox. However, similar applications have yet to be applied to research into communications of intent to suicide. Furthermore, this chapter has shown that a shift in suicide method choices by women in recent decades from poisoning to hanging has not had the predicted increase in the overall female rate. The lack of radical change indicates that there may be more to the gender paradox of suicide than method choice alone. New perspectives that include gender theory as well as a critical sociological reflection on how suicide is understood, and how evidence is collected, and explained are vital to understanding why men die more frequently of suicide than women.

Chapter Three
Methodology and method

The previous chapter described sociological approaches to suicide research and how the sociological autopsy method has developed from critiques of earlier methodologies. The chapter also reviewed the role of gender in suicide research, communications of intent research, and noted the absence of gender. In this chapter we draw upon these insights to outline the methodological approach used in this thesis. The methodology will discuss the reasons the sociological autopsy method was chosen, as well as provide a background for the constructivist nature of suicide research. The methods section explains the two phases of data analysis, the quantitative and qualitative phases, which constitute the sociological autopsy approach applied in this thesis.

Methodology

Fincham et al. (2011:44) refer to the sociological autopsy as a pragmatic approach to researching suicide which uses qualitative and quantitative methods. The qualitative analysis of case studies provides space for an in-depth exploration of the meanings of suicide, while quantitative analysis provides a larger understanding of the "shape and structure of suicidal behaviour", together they retain the "fuzzy messy reality" of how suicidal behaviours manifest (Fincham et al. 2011:44).

This current study analyses closed-case suicides that occurred in Queensland in 2014. At the time of analysis, 2014 was the most recent year available with a full range of closed cases of suicide. Queensland cases were chosen because Queensland police use a standardised investigation form (Bleeser et al., 2010) and contain comprehensive and consistent coronial data, which are dependent upon police narratives and subject to different reporting between coronial jurisdictions (Fincham et al., 2011; Scourfield et al., 2012). Queensland police forms include a psychological autopsy and were created in collaboration with the Australian Institute for Suicide Research and Prevention (Potts et al., 2016), potentially reducing some of the methodological risk of using data not created for researchers. This methodological risk is explained further below.

The study utilises both quantitative and qualitative approaches. Quantitative analyses were used to examine the types of communications of intent and circumstances of responses. However, quantitative methods alone do not allow for the analysis of complexities of relationships, nor the social nuance of whether actions taken had gendered implications, and the meanings behind how the communications were made and what was said. Therefore, the qualitative, case-type aspect of our sociological autopsy allows for this complexity to be retained during analysis.

The sociological autopsy approach was chosen because it is sensitive to the constructed nature of coronial files (discussed in Chapter Two). As argued by Douglas (1967) and Atkinson (1978), it is important to avoid taking an empiricist perspective of the data used to understand suicide, which assumes that the rates of incidents being measured, for example, the suicide rate, is a 'true' figure (McCormick, 2007). Fincham et al. (2011:45) posited that

> "Our [sociological autopsy] approach […] starts from a constructionist perspective and builds towards a more objectivist approach which uses social actors' representations as the raw material through which the workings of the external social world may be recovered".

Drawing upon this approach, in this study no single aspect of the evidence is taken to be an objective 'truth', however, understood together and with context in mind, the sociological autopsy method can, to some extent, illustrate the gendered social forces involved when someone communicated intent and died by suicide.

In the interest of avoiding empiricist assumptions, it is important to note that coronial records of suicides are not constructed primarily for the purposes of research. Douglas (1967) and Atkinson (1978) argued that coronial data was not collected, recorded, or published with researchers in mind and can therefore not be expected to hold everything the researcher needs or expects. The function of these records, therefore, is not to test whether gender norms

played a role in communications of intent, but to provide evidence for why a decision of suicide was made by a coroner[6].

Method

The question 'do gender norms play a role in responses to communications of intent to suicide?' was pragmatically approached through two phases of a sociological autopsy. The first phase (Phase One) involves a quantitative analysis to test variables associated with communications of intent in closed-case suicides in Queensland from 2014. Phase Two of the study involves a qualitative analysis of a selection of cases using the sociological autopsy method to group the cases by themes. It is important to note that the themes in Phase Two involved the inductive selection of cases identified as involving issues around masculinity, flagged during the quantitative phase. These were then thematised using the application of theories of masculinities. The data was analysed in three stages:

1. Screening, extraction and quantification (quantitative stage)
2. Case identification (quantitative to qualitative stage)
3. Thematic analysis (qualitative stage)

Ethics was approved by Macquarie University's Human Research Ethics Committee (HREC) Humanities and Social Sciences (HASS); The Department of Justice and Regulation Human Research Ethics Committee (JHREC); and the National Coronial Information System (NCIS).

Phase One: quantitative phase

During Phase One, case data was extracted from closed case 'intentional self-injuries' (suicides) from Queensland in 2014 on the National Coronial Information System (NCIS).

Permission was obtained to access deidentified data for secondary analysis in this thesis from a national study by Campbell et al, (2019) which included all people who died by suicide in Australia. Dr Campbell prepared a deidentified Excel spreadsheet of NCIS case numbers of

[6]For further analysis on coronial processes please see: Bleeser et al. (2010); Carpenter et al. (2015); Carpenter et al. (2016); Tait and Carpenter (2013); Tait and Carpenter (2015); and Timmermans (2005). For a specific focus on the role of Queensland police in suicide investigations please see Potts et al. (2016).

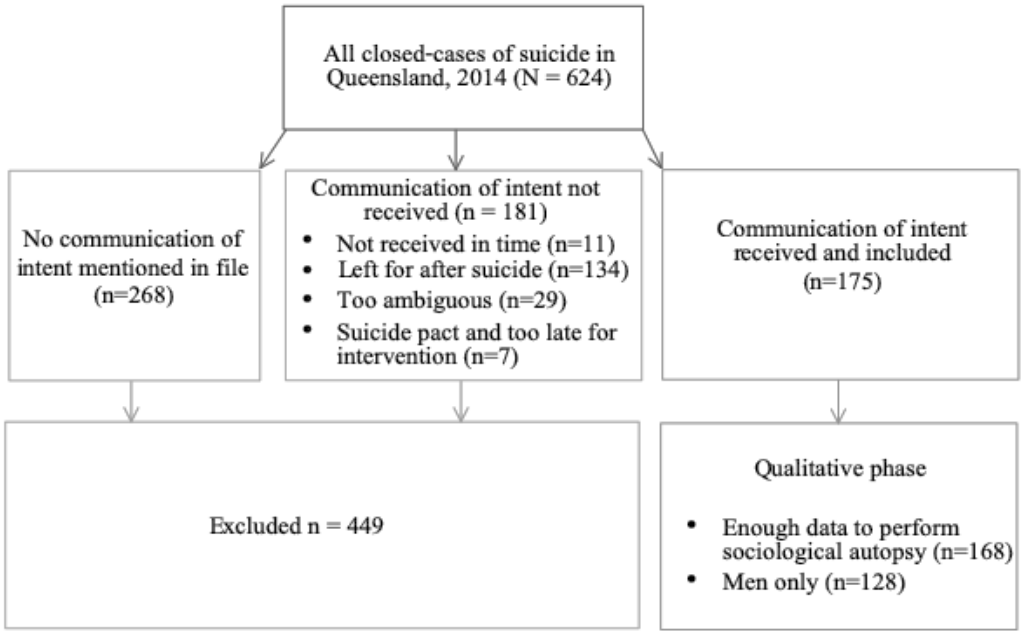
closed-case suicides from Queensland in 2014 (n=602). Eligible cases for the current study were a closed case of suicide that occurred in Queensland during 2014, no exclusions were made on the basis of age or sex.

Variables supplied from Dr Campbell included the age and sex of the case, whether the person had indicated intent, and whether their case mentioned psychosocial factors: a mental illness, job loss, substance use, relationship breakdown, previous self-harm, financial difficulties, loss of children, employment status, and physical health problems. These variables were extended to include others that may have affected the communication of intent: multiple non-fatal suicides, frequent talk or threats of suicide, and whether substance use was mentioned at the time of the communication of intent. These variables were identified from previous literature as reasons participants did or did not respond to communications of intent (see for examples, Owen et al., 2012; Owens et al., 2011; Robins et al., 1959; Wolk-Wasserman, 1986).

Procedure

Each case from Campbell et al.'s study that was coded as having communicated intent was examined using the NCIS. All cases that did not have a communication of intent were coded 'no communication of intent' and not examined further (see Figure One), except to identify the additional variables. Cases that were coded for a communication of intent were inspected for mentions of a communication of intent that were received by recipients prior to suicide. If the communication of intent was deemed too ambiguous and was only recognised as a communication of intent after the suicide, then it was coded 'too ambiguous' and excluded (see Figure One). Communications of intent that were in the form of suicide pacts were also excluded due to their small sample size (n=<5). And communications of intent that were received after death, such as suicide notes were also excluded, due to the recipient's inability to respond (see Figure One). This left 175 cases eligible for both phases of analysis.

Figure One Flow chart of included and excluded cases of suicide identified on the NCIS



Variables of interest -Communications of intent

Variables for the communication of intent extracted were the mode, recipient, timeframe, directness and action taken. Each are explained and defined below.

Mode of communication of intent

Modes of communications of intent were identified and included if they were verbal or text, including short message services (SMS), messages over social media, or emails. If it was unclear or unspecified how the communication of intent was made, the mode was coded 'not specified'. Any communication of intent was included regardless of the mode it took, however, included communications of intent were, was intended to be (and were) received prior to death and involved some level of response before the suicide occurred. Previous non-fatal suicides of the deceased were not included as a communication of intent because the aim of this thesis is to understand responses to communications of intent made *before* suicide, regardless of the outcome. Cases which included, for example, text messages of intent to suicide or suicide notes that were not seen until after death were coded as 'received too late' and excluded (see Figure One).

Recipient of communication of intent

Recipients of the communication of intent were recorded using the terminology used to describe them in the coronial or police report. Usually one of the reports would mention the informants' relationship, such as "long-time friend of the deceased" or "his ex-girlfriend". If it was unclear or not specified who the recipient was, the recipient was coded 'not specified'.

After all cases had been extracted, recipients were coded by relationship to the deceased. For example, people described as "brother", or "uncle" were coded as '*family member*', or people described as "wife", "de facto", or "boyfriend" were coded as '*intimate partner'* indicating a romantic relationship with the deceased.

Recipients were also coded by whether their connection to the suicidal person was as a professional whose role is associated with suicide prevention or intervention (organisational) or not (lay). Therefore, if the recipient was the suicidal person's mother, whose occupation was a nurse or a police officer, this was still coded as a 'lay recipient' or 'lay-level response' not only because the occupation for the recipient was seldom reported, but also to reflect the relationship to the suicidal person.

'*Organisation recipients'* were defined as anyone whose professional role is to prevent suicide. They included *mental health professionals*, *police*, *emergency service workers*, and *hospital staff*. '*Lay recipients'* were defined as anyone whose role in the communication of intent was not a professional who prevents suicide. *Family members*, *intimate partners* and *ex-intimate partners* (no longer in a romantic relationship), *general social group* (such as neighbours or colleagues, and other people that the suicidal person may have come into contact with and was not described as someone from the intimate social sphere), and *social media* (posts made to groups of people online) were coded '*lay recipients'*.

Timeframe of communication of intent

The *timeframe* of the communication of intent was also extracted. Only the last communication of intent before death was quantitatively analysed[7]. This was decided for clarity of analysis and to gain an idea of what interventions people did or did not take before

[7] A different approach was used in Phase Two, which allowed for the analysis of a narrative of communications of intent over time if relevant to the case.

the suicide. There was no maximum timeframe for a communication of intent to have occurred for inclusion.

Due to some communications of intent being made while the person was dying, there was a minimum timeframe applied. For example, very few people told someone their intent after being found as they were dying. Cases of suicidal people who called and made their communication of intent with the recipient and died over the phone were included, because the recipients were unsure what happened and reacted to the communication of intent, not the suicide. If it was unclear or not specified when the communication of intent was made, the timeframe was coded 'not specified'.

Direct and indirect communications of intent

A *direct* communication of intent explicitly mentioned a plan to suicide, for example "I'm going to kill myself" and included more slang versions such as "I'll neck myself" and slightly less explicit such as "I've had enough, I want to die". *Indirect* communications of intent were context-dependent for example "if [someone who died by suicide] can do it, so can I" or allusions to "going to see" or "be with" someone who is dead. These were context specific in that the recipient knew the person being spoken of was dead and that the allusion was to suicide.

Action taken following the communication of intent

A free-text summary of the actions reported following the communication of intent was extracted. If the action was unclear or not specified it was coded 'not specified'.

Following the data extraction phase, action summaries were examined and coded for themes. The last action subsumed the others and it was the final outcome that was coded by theme. For example, if a communication of intent was sent to a brother, who called their mother, and the mother sent the police around, this would be coded as recipient: 'family member', but action: 'involved police'.

Three-tiered categories of response were made by level of intervention; the highest was 'organisational intervention', which included intervention from general practitioners, mental health professionals, police, ambulance, or hospital staff. The second level was 'lay-level

intervention', which included interventions from people coded as friends and family, intimate partners, ex-partners, or the general social group. The third level was 'dismissed'. These were all the cases that did not receive an intervention following their communication of intent. If the response was unclear or not specified, it was coded 'not specified'. Only instances where there were 5 or more cases are reported to protect anonymity of cases and increase the power of the analysis undertaken.

Statistical analysis

Univariate binary logistic regressions were undertaken to identify whether the distributions among variables were statistically significant by gender or responses received, in order to see what types of characteristics are more likely to be associated with one group than the other. Mean ages (normally distributed) were analysed by t-tests for independence to test whether age played a significant role in group association between men and women or types of responses.

Analyses were run using SPSS version 25 (IBM corporation, 2016) in order to test whether there were any significant differences in how men and women made their last communications of intent before suicide, what type of response they received, and what psycho-social factors may have played a role in these responses. Due to the often-small sample sizes within the categories, all odd ratios and binary analyses should be interpreted with caution. Alpha (p) was set at 0.05, standard in quantitative sociological studies (Labovitz, 1986).

Each case with a communication of intent was also briefly summarised. Any interesting themes, patterns, or events were noted in memos and notes (Braun and Clarke, 2006; Denzin and Lincoln, 2005:3), in order to inform Phase Two. As the cases were extracted, a note was made regarding whether there was enough data to perform the qualitative phase. A case was noted to have enough data if there was information reported to gather an understanding of the communications of intent, the recipients, and the responses. In total, 168 cases were identified as sufficient to be included in the second phase, 128 of which were men (see Figure One).

Phase Two: qualitative phase

Phase Two focuses on masculinities and therefore only cases of men who died by suicide are included[8]. This phase examines the role violent, subordinate, and rational masculinities played in responses to communications of intent.

Cases that were identified as holding enough data for a sociological autopsy were carefully reviewed and deductively coded for themes regarding masculinities as identified in both suicide and gender literature. For example, mentions of excessive alcohol use, feeling depressed, but not seeking help are all signs of 'the big build' of depression in men (Brownhill et al., 2005) and are also linked to social expectations of men and health care utilisation (Courtenay, 2000) and help-seeking (Cleary, 2005).

Themes were identified through a process of summarising and coding key aspects of the contexts surrounding, and types of, responses to communications of intent which occurred within case files. Coding was used to identify patterns within the cases which were consistent with theories of masculinities. Men who appeared to perform particular masculinities were then grouped and the aspects of the communications of intent (relationship with recipient, mode, timeframe, and psychosocial backgrounds) were re-examined to find patterns among them. Cases from the NCIS were also frequently revisited to check the accuracy of the summaries or add to them.

Thematic analysis relied heavily on Connell's (1987; 2005) theories of 'masculinities'. To understand masculinities, Connell (2005:76-77) argued that we need to not only recognise the diverse factors which affect how men experience and perform masculinities, but also how these various experiences of masculinities relate to each other. One key aspect of masculinities is that they are behaved and performed for and in relation to other men and all women. Another key aspect is the theory of 'hegemonic masculinity' which Connell defined as:

> *"the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to*

[8] A similar analysis needs to be undertaken for women.

guarantee) the dominant position of men and the subordination of women" (Connell, 2005:77)

Hegemonic masculinity, therefore, is a type of performance that displays and reinforces the notion that men are authorised and entitled to preside over women. Connell also explained that there is a hierarchy within masculinities which puts hegemonic men at the top as the culturally dominant ideal, and non-hegemonic men below them, followed by all women (Connell, 2005:78).

Connell's theory of masculinities provides the framework for the categories used to analyse the cases identified in Phase One. The types of masculinities discussed in this section were deductively applied from Connell's work as identified in the cases. The cases were then categorised by themes of masculinities and reviewed as a group. These groups were not mutually exclusive. Three thematic categories were identified and grouped: violent masculinity, subordinate masculinity, and rational masculinity. Characteristics and patterns within groups that stood out were noted and analysed for their effects on responses. For example, if one particular group of masculinity had more dismissals compared to the other groups then who the recipients were was analysed to look for differences and similarities.

During qualitative analysis it became clear that there were two types of dismissals, which were categorised accordingly as actively dismissed (with interaction), and passively dismissed (ignored), these are explained further in the Results Chapter. The role of violence also became an important factor in responses. None of these three variables were explored in the quantitative phase, only being identified through qualitative analysis.

Following thematic analysis and categorisation, a case reconstruction was performed. The case type reconstructions are semi-fictional overviews of typical characteristics of the whole group of cases within each theme, in order to illustrate the role of masculinities within responses. These case reconstructions were also used as a means of protecting the anonymity of police and coronial informants as well as those who died by suicide. Similar to the ethical considerations made in the sociological autopsies performed by Fincham et al. (2011:51), any identifying information (such as names or addresses) were omitted from case summaries and changed in the case types reported in the results.

Chapter Four
Results

Chapter Two reviewed current sociological understandings of suicide and showed that a gendered interpretation of behaviours is essential to broadening understandings of communications of intent to suicide and the gender paradox. Chapter Three provided an overview of how analysis was undertaken. The aim of Chapter Four is to analyse whether gender norms play a role in communications of intent and, in particular, the responses that follow. The goal of Phase One is to compare the demographics, psychosocial backgrounds, previous suicidal behaviours, types of communications of intent, and responses between men and women. It then focuses on men specifically in order to test for differences and similarities between men who were grouped by the types of responses they received following their communication of intent. The role of masculinities within these responses are explored further in Phase Two of the results, the qualitative phase. Phase Two identifies and compares forms of masculinities using a qualitative analysis of NCIS data to better understand the role of masculinities in responses to communications of intent to suicide.

Phase One: quantitative results

A key finding of this analysis is though there were no differences in the proportions of men and women who made a communication of intent before death, there were significant differences in how recipients responded to suicidal men. Men who were dismissed following their communication of intent were more likely to have communicated to lay people and be identified as someone who frequently talked about suicide. Dismissed men were also significantly more likely than men who received an intervention to have made their communication of intent to an intimate partner or ex-intimate partner. Men who received the highest-level intervention -organisation- were more likely to have communicated intent to family members than men who received lay-level interventions.

Table 1: Demographics, psychosocial backgrounds, and communications of intent (COI) mentioned in coronial files of people who died by suicide in Queensland, 2014

	Total (n=624)	Women (n=148)	Men (n=476)	OR	95% CI
Gender (%)		24	76		
Mean (SD) age at death	44.8 (17.5)	45.1 (17.5)	44.7 (17.5)	.252(a)	-2.818-3.646(b)
Previous suicidal behaviour (mentions, %)					
Previous non-fatal suicide	20.8	26.4	19.1	0.661	0.429-1.017
Multiple non-fatal suicides	7.4	12.2	5.9	**0.451**	**0.242-0.842***
Frequent talk of suicide	10.3	9.5	10.5	1.123	0.602-2.096
Psychosocial background (mentions, %)					
Mental illness	59.3	66.2	57.1	0.680	0.462-1.001
Current substance abuse	16.3	15.5	16.6	1.081	0.652-1.794
Physical illness	11.5	14.9	10.5	0.672	0.392-1.153
Loss of job	9.0	4.7	10.3	**2.311**	**1.024-5.219***
Relationship problems	26.8	18.9	29.2	**1.768**	**1.120-2.790***
Loss of children	6.7	4.1	7.6	1.936	0.799-4.690
Financial difficulties	15.2	16.9	14.7	0.848	0.515-1.397
Previous self-harm	8.3	10.8	7.6	0.675	0.363-1.255
NCIS coded unemployed	23.9	22.3	24.4	0.891	0.574-1.383
NCIS coded employed	32.2	23.6	34.9	**1.729**	**1.132-2.640***
Communications of intent (%)					
COI received prior to death	28.0	25.7	28.8	1.170	0.770-1.778
COI made but not received prior to death	31.1	39.2	28.6	**0.621**	**0.422-0.912***
No COI mentioned in reports	40.9	35.1	42.6	1.373	0.936-2.014

Notes: * p-value=<0.05
(a) T-test for independence
(b) 95% CI for t-test for independence

Characteristics of Queensland sample

There were 624 cases of intentional self-harm (suicide) identified with just under a quarter of the sample (24%) were women, a similar proportion to the number of women who died by suicide nationally in 2014 (ABS, 2016)[9]. As illustrated in Table 1, the mean age of those who died by suicide in Queensland was 44.8 (SD 17.5). Over half the sample (59.3%) had a mental illness recorded in their files, a fifth had previous non-fatal suicides, and 10.3% were identified as someone who frequently talked about suicide. There were no significant

[9] Aboriginal and Torres Strait Islander status was not collected. This information is not immediately at hand in the NCIS and needs to be searched for specifically. This thesis could not provide an adequate context of Aboriginal and Torres Strait Islander suicide in Australia, which requires its own specific analysis.

differences between the proportions of men and women who died by suicide and communicated intent to someone before they died. Men and women were most likely to communicate intent in person and within 24 hours of death (see Table 2). The recipients of the communications of intent varied slightly but not significantly, men most frequently communicated intent to a family member (not including intimate partners) and women most frequently communicated intent to an intimate partner.

Previous Suicidal Behaviour

Among all people who died by suicide, one in five people had a previous non-fatal suicide, with very few significant differences in previous suicidal behaviours between men and women. However, men were less likely than women to have multiple previous non-fatal suicides mentioned in their files (OR 0.451, 95% CI 0.242-0.842, p=0.012).

Psychosocial background

Table 1 provides a list of known risk-factors for suicide in men and women. Men were significantly more likely than women to have mentions in their files of a job loss (OR 2.311, 95% CI 1.024-5.219, p=0.044), and relationship problems (OR 1.768, 95% CI 1.120-2.790, p=0.014). Men were also more likely than women to be coded by the NCIS as employed (OR 1.729 97% CI 1.132-2.640 p=0.011). The majority of men and women had a mental illness mentioned, 57.1% and 66.2% respectively.

Communications of intent

The event of a communication of intent varied to some extent between men and women. Just over a quarter of men and women (28%) who died by suicide made a communication of intent which was received prior to death (28.8% and 25.7%, respectively, see Table 1). Men who died by suicide most frequently made no communication of intent (42.6%, see Table 1). Men who died by suicide were significantly less likely than women to have made a communication of intent that was not received prior to death, for example a suicide note (OR 0.621, 95% CI 0.422-0.912, p=0.015).

Table 2. Characteristics of last communication of intent (COI) before suicide in Queensland, 2014

	Total (n=175)	Women (n=38)	Men (n=137)	OR	95% CI
Recipient of COI (%)					
Family member (not including intimate partners)	24.0	18.4	25.5	1.520	0.614-3.759
Intimate partner	21.7	23.7	21.2	0.865	0.369-2.030
Ex-intimate partner	9.1	§	10.9		
Friend	14.9	15.8	14.6	0.912	0.338-2.460
Recipient -lay	78.9	71.1	81.0	1.739	0.765-3.953
Recipient -organisation	15.4	21.1	13.9	0.604	0.241-1.512
Not specified	5.7	§	5.1	§	
Direct COI	87.4	89.5	86.9	0.778	0.247-2.453
Mode of COI (%)					
In person	51.4	55.3	50.4	0.821	0.399-1.691
Phone call	17.7	21.1	16.8	0.757	0.308-1.860
Text message	17.1	§	19.7	§	
Social media post	2.9	§	§	§	
Not specified	10.9	§	10.9%	§	
Timeframe of COI (%)					
Within 24 hours of death	42.9	47.4	41.6	0.792	0.385-1.629
Month of death (but not last 24 hours)	22.3	21.1	22.6	1.097	0.456-2.635
Over a month before death	18.9	13.2	20.4	1.695	0.606-4.740
Not specified	16.0	18.4	15.3	0.802	0.312-2.058
Response to COI (%)					
Lay level intervention	14.9	§	16.8	§	
Organisation level intervention	32.6	31.6	32.8	1.060	0.490-2.292
Dismissed	17.7	15.8	18.2	1.190	0.450-3.152
Not specified	34.9	44.7	32.1	0.584	0.281-1.217

Notes: § No analyses performed n=<5

Table 2 presents characteristics of the last communication of intent before death (n=175), by recipient, mode, directness, timeframe, and response received. Proportions of communications of intent varied by gender, though not significantly. Communications of intent made by men were most frequently to a family member (25.5%) followed by an intimate partner (21.2%), and friend (14.6%) indicating a reliance by suicidal men on their close social networks. A higher percentage of women than men communicated intent to an organisation (21.1% compared to 13.9%) though this difference was also not significant. The vast majority (87.4%, see Table 2) of communications of intent involved direct mentions of suicidal intent before death.

The mode of communications demonstrated slight but not significant variations between genders. Half of all communications of intent occurred in person (51.4%), followed by text messages by men (19.7%), and phone calls by women (21.1%). The majority (65.2%) of final communications of intent were made within a month of the suicide, the most common being within 24 hours of death (42.9%).

Table 2 also shows the responses received following a communication of intent. The most common response was to involve an organisation, which occurred in approximately a third of cases (32.6%). One in five men (18.2%) were dismissed following their communication of intent, too few women were dismissed to report or statistically compare (n=<5). Table 2 also shows that men were a higher percentage of men were dismissed than received a lay-level intervention.

Table 3 Frequency and logistic regression of men who received an intervention or were dismissed following last communication of intent (COI) to suicide (n=93)

	Received intervention (n=68)	Dismissed (n=25)	OR	95% CI
Mean age at death (a)	40.5	44.5	1.102(b)	3.991-3.621
Psychosocial background (mentions, %)				
Mental illness	66.2	68.0	0.921	0.346-2.451
Current substance abuse	29.4	32.0	0.885	0.329-2.381
Physical illness	8.8	§		
Loss of job	§	§		
Relationship problems	42.6	40.0	1.115	0.439-2.837
Loss of children	8.8	§	1.113	0.209-5.914
Financial difficulties	17.6	20.0	0.857	0.268-2.738
Previous self-harm	11.8	§		
Coded unemployed in NCIS	23.5	40.0	0.462	0.174-1.226
Coded employed in NCIS	35.3	28.0	1.403	0.514-3.831
Previous suicidal behaviour (mentions, %)				
Previous non-fatal suicide	22.1	20.0	1.132	0.364-3.523
Multiple non-fatal suicides	7.4	§		
Frequent talk of suicide	19.1	40.0	**0.355**	**0.130-0.966***
COI recipient (%)				
Recipient -lay	70.6	96.0	**0.100**	**0.013-0.790***
Friend	11.8	20	0.533	0.156-1.818
Family member (not including intimate partner)	29.8	§		
Mental health professional	10.3	0		
Intimate partner	16.2	40.0	**0.289**	**0.104-0.809***
Ex-intimate partner	7.4	24.0	**0.251**	**0.069-0.916***
Mode of COI (%)				
Text message	22.1	20.0	1.132	0.364-3.523
In person	41.2	56.0	0.550	0.218-1.388
Phone call	25.0	20.0	1.333	0.434-4.100
Social media post	§	§	NA	NA
Not specified	8.8	0	NA	NA
Timeframe of COI (%)				
Within 24 hours of death	48.5	72.0	**0.367**	**0.136-0.991***
Within month (but not last 24 hours)	27.9	§		
Over a month before death	17.6	§		
Not specified	§	0	NA	NA
Direct COI (%)	88.2	80.0	1.875	0.550-6.393
Response to COI (%)				
Organisation level intervention	66.2	NA		

Notes: * p-value=<0.05, (a)T-test for independence, (b) 95% CI for t-test for independence, § No analyses performed n=<5

Table 3 (n=93) is a breakdown of men who received an intervention (lay or organisation) or were dismissed, in order to better understand differences between each group. There were several significant differences when examining men alone. Men who received a response were significantly less likely than men who were dismissed to be identified as someone who frequently talked about suicide (OR 0.355, 95% CI 0.130-0.966, p=0.043), have made their communication of intent to a lay person (OR 0.100, 95% CI 0.013-0.790, p=0.029), to an intimate partner (OR 0.289, 95% CI 0.104-0.809, p=0.018) or ex-intimate partner (OR 0.251, 96% CI 0.069-0.916, p=0.036) and to have made the communication of intent within 24 hours of death (OR 0.367, 95% CI 0.136-0.991, p=0.048).

Table 4 Frequency and logistic regression of men who received a lay or organisation-level intervention following last communication of intent (COI) to suicide (n=68)

	Organisation-level intervention (n=45)	Lay-level intervention (n=23)	OR	95% CI
Mean age at death (a)	41.1	39.5	-0.411(b)	-9.310-6.133
Psychosocial background (mentions, %)				
Mental illness	73.3	52.2	2.521	0.881-7.215
Current substance abuse	24.4	39.1	0.503	0.171-1.480
Relationship problems	46.7	34.8	1.641	0.581-4.636
Financial difficulties	22.2	§		
Previous self-harm	17.8	0		
NCIS coded unemployed	17.8	34.8	0.405	0.128-1.279
NCIS coded employed	40.0	26.1	1.889	0.625-5.705
Previous suicidal behaviour (mentions, %)				
Previous non-fatal suicide	17.8	30.4	0.494	0.153-1.595
Frequent talk of suicide	24.4	§		
COI recipient (%)				
Friend	11.1	§		
Family (not including intimate partner)	20.0	47.8	**0.273**	**0.091-0.817***
Intimate partner	15.6	§		
Lay person	55.6	100		
Mode of COI (%)				
Text message	20.0	26.1	0.708	0.217-2.312
In person	51.1	21.7	**3.764**	**1.191-11.891***
Phone call	22.2	30.4	0.653	0.210-2.027
Timeframe of COI (%)				
Within 24 hours of death	37.8	69.6	**0.266**	**0.091-0.777***
Within month (but not last 24 hours)	31.1	21.7	1.626	0.502-5.263
Over a month before death	22.2	§		
Not specified	§	0		
Direct COI (%)	93.3	78.3	3.889	0.839-18.034

Notes: * p-value=<0.05
(a) T-test for independence
(b) 95% CI for t-test for independence
§ No analyses performed n=< 5

Table 4 presents a comparison of characteristics of men who received an organisation-level or lay-level intervention (n=68). Men who received an organisation-level intervention were less likely than men who received a lay-level intervention to have communicated intent to a family member (OR 0.273, 95% CI 0.091-0.817, p=0.020) and to have made their communication of intent within 24 hours of death (OR 0.266 95% CI 0.091-0.777, p=0.015).

Men who received an organisation-level intervention were more likely to have made their communication of intent in person than men who received lay-level interventions (OR 3.764 95% CI 1.191-11.891, p=0.024).

Across the tables we can see men who received organisation-level interventions had the highest percentage of employment (40.0%) and the lowest percentage of unemployment (17.8%) than men who received lay-level interventions (26.1% and 34.8%, respectively), dismissed men (28.0% employed and 40.0% unemployed) and all people who died by suicide (32.2% and 23.9%, respectively). Men who received organisation-level interventions also had a smaller proportion of substances users (24.4%) than men who were dismissed (32.0%) and received lay-level responses (39.1%) and also had the highest percentage of mental illness mentioned in their files (73.3%) compared to all cases of suicide (59.3%), men who were dismissed (68.0%) and men who received lay-level interventions (52.2%).

Discussion: quantitative phase

These findings indicate that gender may play a role in who men and women choose to communicate intent to, however, a larger sample of women is needed to properly test this. Though there were no significant gender differences regarding who was chosen to be a recipient of a communication of intent, men who died by suicide tended not to communicate intent to organisations, with only 13.9% doing so compared to 21.1% of women. These results vary slightly from Robins et al. (1959), who found that women were more likely than men to communicate intent to a physician, indicating a possible shift in attitudes by men towards using health services when in distress. It seems men prefer to discuss their suicidality with lay-people, a similar finding to Player et al. (2015), that suicidal men tend to discuss their distress with a trusted and respected lay person.

The slightly higher percentage of men choosing lay recipients is in line with hegemonic masculine expectations of men being able to manage without formal help (Cleary, 2005; Courtenay, 2000). However, the lack of difference between men and women who communicated intent prior to their suicide challenges gendered understandings of suicidal behaviours, namely that women ‘talk’ and men ‘do’ and are consistent with findings by Rudestam (1971). Similar proportions of a previous non-fatal suicide between men and women also to some extent challenges the gender paradox (that women exhibit more suicidal

behaviours than men), indicating that at least in a sample of cases of suicide, there could be more to the paradox than method choice and access to means.

The use of organisational interventions is an important discovery. Most of the literature that investigated how friends and family members respond to communications of intent, generally found them to be unsure of how to respond (see Kjølseth and Ekeberg, 2012; Orbach et al., 2007; Owen et al., 2012; Owens et al., 2011; Rasmussen et al., 2014; Robins et al., 1959; Rudestam, 1971). Recipients in this study, however, tended to involve an organisation, indicating that policies that try to minimise uncertainty around how to respond may be effective, such as those described by Owens et al. (2011) which focused upon the role of friends and family in suicide prevention. Given that half of the last communications of intent took place in person, we can see a promising intervention opportunity. Unlike other modes of communication of intent, when a communication is made in person the recipient knows where the suicidal person is, may be able to read cues of how acute the suicidality is, and may have a better chance at mobilising organisational help.

A potential drawback to communications of intent made in person is that the suicidal person will likely be extremely sensitive to the response. Previous studies have shown that communications of intent can be a time of anger and frustration for the recipients (Robins et al., 1959) and result in an overall negative experience for the communicator (Latakiene et al., 2016) including their families (Player et al., 2015; Robins et al., 1959) even when in organisational settings such as a hospital (C.R.E.S.P, 2015; Hopkins, 2002). This may be why a response made in person was slightly more associated with receiving a dismissal. Furthermore, the overall outcome of suicide despite a third of cases receiving organisation-interventions remains problematic and raises the question of why, despite the high levels of organisational involvement, individuals still died by suicide? The answer to this question is beyond the scope of this thesis. However, the role of aggression, its link to masculine norms, and the subsequent effects on responses to communications of intent are explored further in the qualitative section.

There was some indication that the psychosocial context of a communication of intent may affect the type of responses received. Men who received organisation-level interventions had the lowest percentages of unemployment and substance use and the highest percentages of employment and mental illness than men who were dismissed or received a lay-level

intervention. The context of psychosocial circumstances and the link to norms of masculinities is explored in detail in the qualitative section.

The relationship the suicidal person had with the recipient also played an important role in responses. Men who were dismissed were most likely to have made their communication of intent to an intimate partner. Men who received an organisation-level response were more likely to have communicated their intent to a family member. The role of norms of masculinity in these responses is also explored in the qualitative section.

The percentage of men and women communicating intent prior to death (28.0%) is slightly different to previous studies. One explanation may be that communications of intent have decreased since previous research was undertaken. Two studies interviewing close friends and family of 119 cases of suicide by Robins et al. (1959) and 100 cases by Rudestam (1971), found that 40% and 60-80% of people directly communicated intent before death. The smaller percentage in this study may also reflect the use of case files rather than interviews, which are tailored to elicit the specific information the researcher is looking for. The smaller percentage in this thesis highlights a potential limitation of relying on coronial case files in suicide research, which are not produced with researchers in mind (Douglas, 1967).

Conclusion: quantitative phase

The quantitative results indicate that gender norms played a slight yet insignificant role in what types of responses suicidal men and women received following a communication of intent, who was communicated to, and how the communication was made. However, it may be that women are more comfortable discussing their suicidality directly with an organisation, a larger sample of women is needed to test this. Social expectations of masculinity may explain why men tended to communicate to lay-people and why men were slightly more likely to be dismissed than women. A theory of masculinities that examines why particular psychosocial factors are associated with dismissal and other psychosocial factors with organisation-interventions may provide a different perspective on why the gender paradox occurs. The ways in which recipients of communication of intent mobilise help (or not) may explain why men are more likely to die by suicide than women, despite women exhibiting more suicidal behaviours. However, the complexities of social relationships and psychosocial factors and their effects on responses, such as the increased

prevalence of lay-level response for men who present a certain masculinity (for example, being a substance user or unemployed) need further analysis, we turn to this next.

Phase Two: qualitative results

In the previous chapter we demonstrated that gender norms may play a role in how recipients respond to suicidal men and women who communicated intent, and that the relationships suicidal men had with the recipients appeared to play a role in the level of response they received, as well as some psychosocial factors such as employment and substance use. This chapter addresses some of the issues posed in the previous chapter, by examining interactions between forms of masculinity performed by men who communicate their intent to suicide and the responses received within these performances of masculinity. It does so by a thematic analysis of case files of men with enough data to perform a sociological autopsy (n=128).

Three key themes of masculinities were identified which played a role in responses to communications of intent: violent masculinity, subordinate masculinity, and rational masculinity. The next three sections briefly introduce the theory behind each theme, followed by an exploration of the role each theme played in responses to communications of intent made by suicidal men. The sections include excerpts from coronial case files in order to provide evidence of the circumstances around the communications of intent and responses. Multiple cases analysed in each theme were also used to reconstruct 'case types' which characterise a typical communication of intent and response and are used to provide a consolidated example illustrative of the issues within that theme.

Theme one: the role of violent masculinity in responses to communications of intent

Violent masculinity refers to men who use violence and aggression to dominate other people. Responses to violent masculinity were typified by a power struggle between suicidal men and their (all female) intimate partners who were also the victims of his violence.

Physical and mental strength permeate notions of hegemonic masculinity. Hegemonic masculinity involves culturally defined 'ideal' male behaviours that propagate the superiority of some men over others and maintains patriarchy (Connell, 1987; Connell, 2005). Hegemonic masculine behaviours are also distinctly behaviours that are not associated with femininity. According to Connell (1987:85) mental and physical 'toughness' are highly

associated with hegemonic masculinity, involving a domination display of strong men over weaker men and all women. The association of strength with masculinity is indicative of the gendered dichotomy of 'real' men being 'hard' and 'strong', while women (and non-hegemonic men) are 'soft', 'weak', and helpless against hegemonic masculine determination and strength (Connell, 1987:85; Connell, 2005:83). Nevertheless, due to its close proximity to violence, a key aspect of hegemonic masculinity is that it is socially unacceptable to hit 'down'. Violence by men against women is socially deplored, despite the high rates of violence towards women by men (Cox, 2016:2), and indicates a contradiction in how men are expected to behave and how some men actually do. Masculine strength performed through violence over someone else is, therefore, a system of power, a means by which one person (or group) can control another. In the cases below, the display involves power of men over women.

Mentions of violence were identified in 21 of the 128 files of men. Violence was identified and coded within files that mentioned physical violence, such as punching; formal responses to violence such as Domestic Violence Orders (DVOs) or other protection orders which are issued by Queensland police or courts following accusations of domestic violence (Parliament of Queensland, 2012); and included other violent behaviours such as aggression and violent outbursts.

Violent masculinity almost always resulted in a 'passive dismissal' when the recipient was the victim of the violence. A passive dismissal[10] refers to a response where there was no engagement with the communication of intent. Responses were coded passive dismissal when recipients reported to police that they, for example, "dismissed it" or other indications that nothing happened following the communication. An 'active dismissal' refers to a response where there was an engagement with the communication of intent before dismissal, usually words like "don't be stupid" or "stop being silly" before ending the conversation. Implicit in an active dismissal is that the man has or should have some control over his emotions, while in a passive dismissal it appeared to be implied that the man had lost control and the recipient was unsure or uncomfortable with his emotional display, associated with femininity.

[10] The terms 'active' and 'passive' dismissal will be used throughout the remainder of this section to refer to these types of dismissal. The term 'dismissal' is an umbrella term that refers to both types (no intervention).

A common theme among violent men was an attempt to re-establish control over a woman who no longer wished to be in an intimate relationship with him. Use of violence by men who perpetrate domestic abuse has been described as a means to "restore balance" in the relationship and force communication over something that the victim did which upset the perpetrator (Flink and Paavilainen, 2008:249). The theme of restoration of authority and control over a partner who emotionally hurt the men was common in all the cases of violent masculinity examined here.

Masculinity played a role in responses to communications of intent in two different ways, depending on the recipients' relationship to the suicidal man. The most common recipient of the communication of intent was the victim of the violence (n=12), all were female victims of intimate partner violence. The responses of these women were characteristic of a gendered power dynamic, in which the women were resistant to submitting to the will of their male partners.

The role of violent masculinity played a less direct role in responses to communications of intent made to friends and family members who were not the victims of the violence. Such responses were more in line with *subordinated masculinity* in 5 cases and are explored in that section. Of the 12 women who received a communication of intent by a man who was physically or verbally threatening her, all but one communication involved threats to kill himself unless she did not resume the relationship with him or coerce her into not ending a romantic relationship. The ages of the men ranged from 30s to late 60s. The communications of intent were all made in a threatening and aggressive way, for example "*where the fuk r u cunt ya got 5 mins […] just me and the rope now*", sometimes accompanied with direct threats to the woman's life for example, "*I'll hang us both cause I'm not going down for killing you, you scum slut*". The communications of intent were usually made in person or by text message. For example, after one woman spent the night with a friend after her partner had threatened both their safety, he wrote a text message to her saying, "*last time I try I'm looking for the rope as you don't care and without you I can't survive […]"*. The women responded most commonly by avoiding the communication of intent completely and not engaging with it at all.

A common theme of an assertion of *female independence* was identified in these cases. As mentioned above, violence was used as a means of domination through a display of

masculinised strength. Women (and subordinate men) are expected to yield to these displays of power. Though many of the women were victims of domestic abuse, their partners appeared to have few options within the relationship to use as leverage over them, except for violence. Very few of the women had children with the man threatening suicide, few were married or in a long-term relationship with them. Some of the women also seemed to be financially independent of the men. For example, one coroner noted, *"[He] would stay with [girlfriend] […] The last 6 months prior to the death [she] had rented a place […]*". Marriage and long-term commitment, children, and financial dependence are all reasons many women stay in abusive relationships (Cravens et al., 2015). It may be that many of the men were dependent on their partners, with the ending of the relationship signifying more than just the loss of a partner, but also a loss of hegemonic status and a need to find somewhere else to go.

Furthermore, the women threatened their partner's masculine identity and reinforced their own independence by involving police after the abuse. All of the cases involved the police at some stage to intervene in the domestic violence issues within the relationship, many of the police encounters involved an issuing of a domestic violence order. Doing this criminalised the men's behaviour and brought it out from the private into the public world, identifying him as a perpetrator of domestic violence. Finally, the women threatened their partner's masculine-identity and affirmed their independence by deciding to end the relationship against his wishes and despite his threats to suicide. The use of blame and manipulation by the men is exemplified in one text message sent not long before his suicide, from a man whose girlfriend had left him after a period of heightened violence and threats to her life. The police had served him earlier in the day for breaching a previous domestic violence order. Excerpts from the text exchange were as follows:

> *"Why did you do all of this?"* he wrote, *"I didn't deserve to be treated the way I was, but neither did you. It didn't have to happen. […] I know you don't believe me, but wait and see. It will be done by morning. I promise. […] come back before it's too late".* She replied, "*it already is.*"

These themes are consolidated in the reconstructed case type one, below.

Reconstructed case type one

Chris is in his late thirties and has been discovered dead by a friend. Police found on his phone a series of texts and phone calls to a woman named Lisa, who they subsequently interviewed. Chris had been sending increasingly aggressive texts to Lisa, his girlfriend. She was staying with a friend after they had a fight the night before. She had returned home from work and they got into an argument about his failure to find a job. Lisa told him that their relationship of a couple years was over, and she wanted him to move out. He had punched her and threatened to kill her if she left him. She managed to leave and reported his behaviour to police, to whom she detailed other instances in which Chris had physically and verbally abused her. The police turned up at Chris' door and served him a notice to appear in court regarding the allegations in a few days. Chris was furious. His texts began to escalate to threats of suicide if she did not come back home to resolve their problems. Lisa's responses reiterated the end of the relationship and did not engage with the threats, instead reminding him that she would return with police in the morning to make sure he was gone.

Several gendered themes are evident in this reconstructed case type, *age and loss of hegemonic honour, female independence*, and *expectations of traditional femininity*. Chris' age is important in terms of gendered behaviours and expectations of men at mid-life. It is socially expected that men at this age to have started or be starting a family. A level of hegemonic honour gained by men who have a family, which when threatened by a relationship breakdown, appears to often profoundly affect middle-aged men who die by suicide (Scourfield, 2005). A threat to or loss of the provider role by way of unemployment, financial strains, and relationship breakdowns are all common in men who suicide during mid-life, a crucial age by which these roles are expected to be established (Shiner et al., 2009). Case type one, and a finding in this section in general, illustrates these expectations when Chris' intimate partner, Lisa, brought attention to Chris' lack of employment, and in doing so showed her disappointment at his inability to live up to expectations by withdrawing his claim to hegemonic honour: his relationship with her.

Cases of violent, suicidal men who threatened their victims with suicide were likely attempting to get some sort of response from their intimate partners. Men who domestically abuse their partners often do so to get their partners' attention and communicate their distress

(Flink and Paavilainen, 2008). These cases were therefore likely attempts to convey their distress over the end of the relationship as well as re-dominate their partners. Chris' threats in case type one depicts the ways violent men tried to manipulate and bully their partners into resuming the relationship. However, in these cases it was likely that if the women had returned, they would be subject to further abuse, which appears to be an important factor in their responses to communications of intent being a dismissal.

A theme of control and an assertion of *feminine independence* common in the cases of violent masculinity is also present in case type one. Flink and Paavilainen (2008) found that men who domestically abuse their partners do so to regain control. Chris' loss of control through Lisa's claim to it was subtly used against her, as it was for all the women she represents. Violent men continued the abuse by threatening suicide to ensure that their partner felt that his suicide was her fault and something that she wanted and caused. The men undermined their partner's newfound control by overwhelming her with it – if she wanted control, then she controlled whether he lived or died. The use of control against her is a reference to forms of hegemonic masculinity and the display of strength, the presumption being that women cannot handle being in control, are not truly in control and should give up trying to be.

Finally, a theme of tensions between *gendered expectations of femininity* is demonstrated in case type one. Through Lisa's refusal to yield to Chris' threats of suicide and resume their relationship, Lisa reinforced her decision to reject him. Cleary (2005) found that men in distress preferred to talk to women, because they felt that women were better at dealing with emotions and were therefore considered less likely to reject their feelings when men were at their most vulnerable: discussing their emotional weaknesses (i.e. emasculating themselves). In the gendered division of labour, which is a foundational aspect of hegemonic masculinity (Connell, 2005), women, including Lisa and the women she represents, are expected to be nurturers. When a victim did not respond in a nurturing way, she reiterated her rejection of him as a partner and a man. Lisa, and the women she represents, also resisted expectations of femininity by refusing to remain helpless and fearful after a display of masculine power, possibly furthering their partner's experience of emasculation.

Theme two: subordinate masculinity; performances of hyper-masculinity and 'the big-build'

Subordinate masculinity was deeply implicated in how recipients responded to communications of intent. Subordinate masculinity is defined by Connell (2005:78-9) as "a symbolic expulsion from hegemonic masculinity", or a masculinity that does not adhere to the rules of hegemonic masculinity and instead performs behaviours that are expected of women. In order to compensate for or hide this subordinated status, some men may engage in 'hyper-masculine' performances that attempt to re-assert their independence and give the allusion that they are managing their distress on their own, like a 'strong' man should.

Subordinate masculinity was identified in cases where male displays of behaviour associated with hyper-masculinity that were used to compensate for and/or hide distress were mentioned. Hyper-masculine behaviours as performances of distress have been described in health research as a 'big build' that include behaviours to avoid (not think about or engage with distress), numb (using drugs and alcohol to numb the distress) or escape (using substances or other means to physically or mentally escape), whatever is distressing them (Brownhill et al., 2005). These avoidance behaviours may build up to aggression towards people, such as friends and family, as a means of release, and possibly spill out into suicidal or other risk-taking and life-threatening behaviour (Brownhill et al., 2005). The big build is a mechanism used to hide and contain men's inner pain and project a strong, controlled image instead (Brownhill et al., 2005:926). Big build behaviours may also be used as a means of rejecting the perceived 'feminine subject position' of regular health-service users, as described by male participants in a study by Noone and Stephens (2008:717-718), which is oppositional to masculine norms of 'agency' and control. Therefore, cases that mentioned indications of the 'big build' such as refusing medication or therapy when it was recommended, increases in distancing, such as descriptions of the men no longer engaging with informants in the months or days before death, and mentions of recent changes in behaviour, such as increased alcohol and substance use, were coded 'subordinate'. These behaviours indicated subordination due to their approximation to 'hiding' distress through overcompensation via hyper-masculinised performances. These indicators became evident from reading the case files and were subsequently coded as the basis for this theme.

Subordinate masculinity was identified as a common theme in 24 cases. In comparison to violent men, the recipients of and responses to communications of intent made by subordinate men were more diverse. Intimate partners were the main recipient of these communications of intent, all 11 were women, 4 of whom were ex-intimate partners. Family members made up 8 recipients, usually immediate family members. The remaining recipients were friends in 4 cases, and a personal care attendant.

The kind of response these men received to their communication of intent differed by whom the communication was made to. Family members were the only group who responded to subordinate masculinity by taking the men to hospital (in 3 cases), otherwise their responses were lay-level (in 4 cases) and there was one case of dismissal. Friends were the last group, 2 cases responded with lay-level interventions and 2 dismissed their suicidal friend's communication of intent. Finally, there was a case involving the personal care attendant, while it was mentioned that they discussed his suicidality "*at length*" the response did not go beyond that.

Unlike the power struggle that characterised responses to violent masculinity, subordinate masculinity was typified by responses that appeared to grapple with how to best show support to the man without jeopardising his masculinity. Recipients, compensated for the man's subordination by trying to allow him to remain as independent as possible, despite his clear inability to cope. Furthermore, recipients of communications of intent that responded to men who were coded both violent and subordinate were not the victims of his violence, indicating a very different power relationship. Instead they were friends and family members who knew of the violence and interpreted it as a signal that the man needed some level of intervention.

The role of subordinate masculinity in communications of intent made to intimate partners

Intimate partners who received communications of intent in the context of subordinate masculinity were all women. Their relationships with the men were often romantic, however three cases included women who were no longer in this type of relationship with the men. Of the 11 men, 8 were dismissed following their communication of intent, 4 were passively dismissed and 4 were actively dismissed. Passive dismissals were characterised by recipients

who did not believe the man would suicide and involved a lack of engagement with the communication, but without the power struggle indicative of a dismissal in response to violent masculinity. Many informants who passively dismissed their suicidal partner were reported by police as saying, "*she dismissed it*" or "*she did not think he would do it*".

Women who actively dismissed their partners communication of intent reported some level of engagement before dismissal. For example, a woman reported to police after her intimate partner came home drunk the night of his death that "*he had his head down and seemed depressed"* he reportedly stated, *"I have lost all of my money and I might as well top myself."* She replied, *"Don't be silly, have some dinner, there is chicken in the fridge"*. She then left him to go out for the evening.

There were some differences in the circumstances of the men who were actively and passively dismissed following their communications of intent which may have affected responses. Passively dismissed men appeared to have been further along in the 'big build' indicated in several ways, such as more indications of substance use, recent relationship breakdowns, and having a history of suicidal behaviour. All the men who were passively dismissed were identified as someone misusing substances compared to two who were actively dismissed. One woman described passively dismissing her daily methamphetamine-using, ex-partner, who, following her refusal to reconcile their relationship said, "*I guess I should just go neck myself*" as "*just rambling*". Another woman passively dismissed her ex-partner after saying she was heading to bed, "*the deceased made numerous threats to his life. [She] ignored him as she thought he was just drunk and joking around*." Passively dismissed men also generally had extensive histories of suicidal behaviour including non-fatal suicides as well as being described as frequently talking about suicide. In one case, in which the last communication of intent was passively dismissed, a partner detailed a history of her active dismissals when he began showing signs of suicidality: "*His wife took the noose down on both occasions and said don't be silly. She thought he was just attention seeking."* It may be that women passively dismissed their partners who were perceived as overly emotional, out of control and had said or done similar acts previously and survived; while men who still give at least the impression that they were managing their distress were actively dismissed.

The illusion of control by actively dismissed men was exemplified by descriptions of their mental health. Unlike passively dismissed men, who seemed to have completely spiralled

into the 'big build' through drug use and histories of self-harm, actively dismissed men seemed to be assumed to still be somewhat in control. Many of the actively dismissed men had a mental disorder or were described as depressed but not diagnosed or seeking treatment. For example, one man, who recently suffered a brain injury that affected his mobility was described as someone who "*used to sit at the front door of his residence with his head in his hands*". His doctor reported to the coroner that he never once mentioned any issues that may have indicated he was feeling depressed or suicidal about his changes in physical health. Drawing from the NCIS cases, case type two explores in detail the role of subordinate masculinity in active and passive dismissals by intimate partners.

Reconstructed case type two

Marie has just found her husband of over 30 years, Mark, dead. Police asked her whether there was any indication that he may have been suicidal. She recalls that he had mentioned suicide a couple of times over their marriage. Mark has always become upset over small things and had been drinking more frequently than he used to. She told police that many years ago, when they were first married, he had lost his job and become depressed. He had mentioned then that he wanted to kill himself. At the time she told him not to be so stupid and left for work. He had been to the doctor around that time. The doctor suggested he try antidepressants, but Mark did not fill in the prescription. Then some months ago, Mark lost his job again due to a workplace injury. He did not think he would work again and had to draw a disability pension. She had never seen him like this. He was barely eating or sleeping. He spent most of his days looking out the window. He didn't engage with her much at all in the last few months and when he did, he was short tempered. The day before his death, they were discussing their budget when he said that he should just go kill himself. She told police she dismissed the comment. They had shared a bottle of wine and he had some beers before that, she thought he was just grumbling and drunk as usual. She didn't ever think that he would actually do it.

Reconstructed case type two represents key issues that occurred in the cases where men performed subordinate masculinity to intimate partners: *male suicidality and management of men's emotions*, *expected feminine responses* to these displays, *compensation for subordination* and *not living up to expectations of men*.

Managing men's emotions and suicidality is a key theme in case type two. Marie's first response involved an active dismissal representing how some women deflected their partner's cues regarding their health. Following the active dismissal, there is an assumption that Mark is still capable of managing his emotions and that his suicidality is a "stupid" response to his problems. Such a response to men's suicidality may be a reason why many men who were actively dismissed did not seek treatment, despite their behaviours being identified by their intimate partners and described to police as sad and depressed.

Compensating for subordination is also apparent in case type two thorough Mark's attempt to hold onto some level of machismo after a loss of hegemonic ideals. Mark represents cases of men who attempted to deal with a loss of claims to hegemonic honour, such as a job, by compensating in another area, such as remaining stoic and refusing treatment for depression, against his doctor's recommendations. To accept medication for a mental illness could be associated with the feminised, subjugated (subordinated) status (Chrisler and McHugh, 2018). When Mark became suicidal again, he was dealing with a deeply failed masculinity. He no longer had a job, he was physically ill, he was dependent on the government for income, and when he was most vulnerable, he told his wife that he was suicidal, implying he was not coping, and she did nothing.

Marie, like many other recipients of communications of intent in this category was negotiating her partner's machismo. She, and the other female intimate partners she represents, would be aware of the stigma associated with male depression and mental illness (Reavley and Jorm, 2011). The active dismissals made by intimate partners perpetuated and reinforced a common-held belief that men are in control of themselves and should be able to manage their emotions. This may be why women actively dismiss their partners who are performing distress in traditionally masculine ways. The suicidal men performed distress in a way that conforms with broader social expectations, as distress under control. For example, a man who chooses to drink alcohol instead of seeking medical treatment for depression is managing his emotions in a socially sanctioned way. Behaviours associated with the 'big build' did not occur in a vacuum, they are learned through socially condoned behaviours, and are used by some men to deal with distress in ways that maintain hegemonic ideals: stoicism, independence, rationality and agency. Mark, like the men he represents, decided not to engage with treatment. Instead he invoked a masculine discourse of 'strength' in the face of

potential subordination and rejected the feminised-patient subjugated position of passivity and irrationality associated with mental illness by avoiding treatment. Marie negotiated Mark's subordination by invoking discourses that reinforced her expectations of his ability to manage.

Finally, reconstructed case type two provides insight into a clash of gendered expectations observed within cases of subordinated men who communicated their intent to their (female) intimate partners. It is reasonable to assume that men who communicated intent wanted some sort of response. Marie, and the other women who dismissed their intimate partners, did not respond to Mark as she "should" have, or as would be expected. Like violent men, subordinate men who communicated intent to their intimate partners likely expected them to respond in a nurturing and caring way. Contrary to partners of violent men, these women attempted to negotiate their partner's decisions to not be subjugated, it would seem from the cases that some women responded in a way that they think their partner would have wanted: by allowing him to manage on his own.

The case type indicates that in cases of dismissals the depreciation of the men's hegemonic honour to subordinated masculinity were concurrent with a withdrawal of traditional femininity in response to communications of intent. By drawing from these cases of women who dismissed their intimate partners following a communication of intent, it may be that tensions between traditional gendered expectations heightened the suicidal men's experience of subordination and emasculation.

The role of subordinate masculinity in communications of intent made to friends

A very different negotiation of subordinate masculinity played a role in the four cases where communications of intent were made to friends. As the last section showed, responses by intimate partners were characterised by a clash of expectations between masculinity and femininity. Responses by friends, who were all men, were characterised by varying relations and tensions between masculinities. One difference, which also differed from responses to violent masculinity, was that men who were violent towards their intimate partners received lay-level responses from friends in two cases. The violence therefore played a different role in responses when it was not directed at the recipients, and instead was interpreted as a signal

for intervention and support. Two other men were dismissed following their communication of intent made to a friend. This suggests that a differentiated response to violence might need to be considered, that takes into account variations of power in different types of relationships.

The two cases of violence were interpreted in conjunction with other displays indicative of the 'big build', including aggression and substance use. In one case of a violent man, the friend "*noticed a change in [suicidal friend's] demeanour*" and noted he had started to drink harder liquor. When he received a call from another friend that he was about to suicide, he "*got into his car and drove straight there*". This friend also informed police that his friend's partner frequently left with the kids to a women's refuge, indicating a knowledge of his friend's violence towards her.

The other two cases of men who made a communication of intent to a friend did so without the context of violence and suggested very different responses to subordinate masculinity. Both men were drunk at the time of the communication and both men's communication were dismissed by their friends. One was actively dismissed. After telling his friend he wanted to suicide he replied, "*not to think like that and not to be an idiot*". The other man was passively dismissed. Police reported "*the deceased was intoxicated at the time and [friend] did not believe that he would follow through with his threat*". Case type three, draws upon these findings to consolidate the issues pertaining to this theme.

Reconstructed case type three

Charlie is in his forties and has just been let go from his job. That night at the pub he was drinking with a workmate, Mike. They had been drinking spirits instead of beer because Charlie insisted he needed something stronger. After some hours Charlie told Mike he might hang himself. Mike told him not to say things like that and they did not talk about it again. Mike later told police that he just thought Charlie was drunk. Charlie's friend, Frank, heard about Charlie's unemployment and called to see how he was going. Over the phone Charlie sounded really depressed. Frank was worried, Charlie's partner of ten years had left him a couple of months ago and he did not take it well, he'd been drinking heavily ever since. Frank said he'd stop by the next morning. When he got there, Charlie was clearly intoxicated, he said he'd screwed everything up and that he wanted to kill himself. Frank noticed that there were smashed beer bottles around the house. He had to leave for work but told Charlie he would check in the rest of the day. After Frank's shift ended, he grew concerned that Charlie had not responded for some time. He got a call from a mutual friend saying that Charlie had called him and said he was going to hang himself. Frank immediately got into his car and drove to Charlie's house. He found him unresponsive and called an ambulance.

Case type three illustrates two different responses to cases of subordinate men who communicated intent to a friend, through themes of *homophobia*, and *heroic masculinity*. While Frank's lay-level intervention can be read as a different interpretation of Charlie's behaviour as well as a different relationship with masculinity, Mike's active dismissal is in line with Kimmel's (1997) theory of hegemonic masculinity as homophobic.

A theme of *homophobia* is implicit in Mike's response. Kimmel (1997:277) argued that homophobia runs deeper than a fear of being identified as gay, but as a fear of being 'outed' by other men as feminine, or a man who does not measure up to hegemonic forms of masculinity (i.e. subordinated). As indicated in the previous section on subordinate men, there is evidence that some men prefer to disclose emotional distress to subordinated people, such as women, due to the taboo associated with displaying emotions to other men (Cleary, 2005). Some men who attempt to engage in emotional talk with other men do so as a means of 'identifying sympathetic individuals' (Cleary, 2005:170). Because masculinity is defined

by other men, looking for someone to share emotions with is not in itself indicative of subordinate masculinity, but the responses of other men who receive the emotional display may create an experience of subordination. Mike's response is illustrative of this gendered power display. Not only was Charlie breaching taboo by discussing his emotions with another man but in doing so, he erroneously identified Mike as potentially sympathetic (and therefore subordinate). In order to disengage from and shut down a display of subordinate masculinity, Mike subordinated Charlie and compensated for the misunderstanding by dismissing Charlie's display of emotions and suicidality as "stupid".

The case summary also emphasises a different dimension, *heroic masculinity*. Frank's response can be read as a performance of a heroic gesture, consistent with forms of hegemonic masculinity. Cleary (2005:169) emphasised that an aspect of masculine performance of men is liking *to save* not *be saved*, and that certain expressions of masculinity find the passive position in help seeking difficult to come to terms with (Cleary, 2005:169). In drawing upon those responses in the coronial files where men actively responded, Frank's response shows that some men can put aside potential connotations of homosexuality and subordination to help someone close to them. Perhaps Frank's hegemonic honour rests on his ability to be depended on by those close to him.

The role of subordinate masculinity in communications of intent made to family members

Family responses were slightly different from friends and female intimate partners and reflected again the different expectations, power dynamics, and type of relationship the men had with the recipients of the communications of intent.

The sense of support that family members are expected to provide may clash with their ability to negotiate the masculinity of a suicidal man experiencing subordination. Responses by some family members were characterised by a similar pattern as intimate partners, by a need to negotiate the man's subordinate status by trying to provide support without subjugating him further. However, unlike intimate partners, communications of intent made to family members usually resulted in lay-level interventions. In other cases, families attempted to get men hospitalised after they identified that the man had lost control of his

circumstances and was communicating intent to suicide, for example, through increased substance use, violence, and displays of mental illness.

Lay-level responses by family members included counselling the man or making arrangements to spend time together. For example, the mother of a man said that he spoke about killing himself every day. He was diagnosed with various mental illnesses but was not taking his prescribed medication because he "*did not like going to the doctors*". Instead, he drank and smoked "*most of the time*" and took paracetamol "*like lollies*". She had taken him once to see a mental health practitioner, but he had not been for years. Instead, she was usually able to calm him down when he was feeling suicidal by talking to him about it.

Family members were the only recipients who tried to hospitalise suicidal men performing distress in a context of subordination. The families of three men attempted to hospitalise them as a way of seeking support. Two were identified as violent, and both had been drinking more than usual. Both were also identified as not coping at all with their situations, leading the families to involve medical intervention. One violent man frequently was taken to hospital following a communication of intent. He was also hospitalised for non-fatal suicides and it was noted in the coronial files that he was usually only treated for his injuries. After one incident, his sister told the coroner that they were told by outpatient hospital staff that there "*was not much more they could do for him as he had a place to live and his family was supporting him*". They told him to continue seeing the psychologist and left him in the care of his family.

The role of subordinate masculinity in responses to communications of intent made to family members are explored in reconstructed case type four.

Reconstructed case type four

Richard is in his late thirties and recently moved in with his parents. His partner ended things a few weeks ago and he had nowhere else to go. He had cried to his sister on the phone, mentioning that he was worried he would lose his job because of all the time he'd taken off and not be able to repay his debts. She could tell he was drunk. He said he was scared and was writing a suicide note. His sister called their parents, and their father immediately went over to pick him up. That night the family had a long chat about how he got this bad. They discussed what steps he would need to take to get better. He agreed to go to hospital and seek treatment. He was not hospitalised, but he was referred to a psychologist who prescribed anti-depressants, that was the only time Richard saw the psychologist, he did not think she helped much. Whenever Richard was feeling down, or his parents thought he was not doing well, they would come together as a family and discuss it. Sometimes Richard would be there and sometimes he was too annoyed and would stay in his room. The family figured as long as Richard was talking about his problems, he was OK, and he always seemed better when he talked. Richard continued to drink every night and occasionally smoked cannabis. After his father asked why he stopped taking his medication, Richard said that a beer and some weed did just as good a job.

As case type four shows, family member responses were characterised by a desire to allow the man some autonomy over how he dealt with his emotions and to keep the man's suicidality private and within the family. The need to provide their own support, may stem from a fear of further emasculating the men by subjecting them to formal health services. Like many of the families negotiating a suicidal man experiencing subordination, when the behaviour reached crisis point, Richard's family attempted to involve medical intervention with his consent. Importantly, the case type highlights a common issue observed within the coronial files, that formal health services deemed Richard's family network as sufficient to support him.

Case type four also explores a common lay-level response undertaken by many family members reported in the coronial files, which was to simply talk to and spend time with the suicidal men in order to provide them with support during a crisis. For many subordinated

men, chatting to their loved ones was enough to calm them down. This may be because there is less of a need to display masculinity among family members, whom men are not expected to provide for, reflecting a very different relationship of support to significant others and friends. In the cases analysed here, suicidal men who have family members they can discuss their feelings with may experience better integration. The reciprocal bonds formed with family members may be strong enough to allow them to be vulnerable without fear of being socially emasculated, allowing for a continued safe space for these men to express themselves.

Theme three: the role of rational masculinity or 'good men' in responses to communications of intent

The concept of 'good men' not coping was the third category identified in the cases. These men were initially coded as 'good men' due to their adherence to public health ideals of what suicidal people should do in a crisis: seek support and treatment. Additionally, following their categorisation it was found that this group of men also demonstrated behaviours associated with responsible masculinity –for example, they were employed, in stable relationships, or had reasonable relationships with ex-partners, none were they violent nor did many have substance abuse issues. All but one had a diagnosed mental illness. This group therefore conforms with the dominant stereotype of suicidal behaviour being associated with psychiatric illness.

Good men were identified by an apparent openness about their suicidality, an openness to seeking treatment and a commitment to get better, in contrast to men in the previous categories. Many of the men appeared to have close friends and family with whom they were open about their suicidality and treatment, indicating a sense of security in these relationships that would not threaten their sense of masculinity. The vast majority of responses to good men involved organisations such as mental health professionals and hospitals.

Rational masculinity is part of hegemonic masculinity, according to Connell (2005:164), because it "embod[ies] the power of reason, and thus represent[s] the values of the whole society". Connell argues that hegemonic masculinity is upheld due to the implicit dichotomy of men as 'reasonable' and women as 'emotional' (Connell 2005:164). Masculine honour for some men is deeply entwined with their ability to remain emotionally, mentally, and

physically healthy (O'Brien et al., 2005). It is reasonable then, that some men, when faced with depression and suicidality want to solve the issue causing distress, instead of trying to avoid, numb, or escape it.

The good men deviated from men who embodied subordinated and violent masculinities because they did not perform distress in traditionally masculine ways. They also all received an intervention, regardless of who the recipient was. None of the good men were dismissed following their communication of intent, indicating recipients were less unsure about how to respond because there was no need to struggle for power, like violent men; and no need to negotiate his masculinity, like subordinate men. Because of these factors, responses to communications of intent made by men of reason, were different to those made to violent and subordinated men. The lack of anti-social characteristics gave people within their support networks a better chance at providing support when they needed it because they did not have to navigate and negotiate with their sense of masculinity.

Over a quarter of good men communicated intent directly to an organisation, indicating a willingness to access these services. A key finding from the analysis is that all good men received some level of intervention following the communication of intent, the majority of which were organisational. Of the 25 men, 9 were taken to hospital, 5 were taken to a mental health professional, 6 involved police for welfare checks, 5 lay interventions involved counselling and informal support. One lay-level intervention involved an incredible show of support. A man, "*asked the deceased to move in after hearing he had suicidal thought*s" which he accepted. They had been living together for a few months when he died. The suicidal man was an acquaintance, middle-aged, unemployed, and did not appear to have a family (no family members were mentioned in his file). His housemate's response provides evidence that men can and do provide incredible support to one another, if they are willing to accept it.

Another aspect of good men that differed from violent and subordinate men were the responses by intimate partners. Almost all intimate partners of violent and subordinate men dismissed the communications of intent in some way. All but one of the intimate partners of good men, all of whom were also women (2 were ex-intimate partners), who received the communications of intent (n=8) responded by involving police, a hospital, or other mental

health professional. For example, the partner of one man took him to hospital twice before he died. Two months before his death his partner told police that,

> *"the deceased was very depressed and was talking about suicide and was looking up methods of suicide on the internet. [Partner] observed the deceased leave their residence with what appeared to be a cord. [She] contacted QAS [Queensland Ambulance Service] and advised them of the situation. QAS and police arrived when the deceased returned. The deceased was taken for an [emergency examination] however later released due to no signs of mental health."*

One case in particular typified the 'good man'. According to a coronial report, the suicidal man called his daughter "*stating that he was feeling suicidal and requesting her to come and get him. She picked him up and took him to the adult mental health unit but he […] wanted to go to [a private hospital]*." He had also informed his former partner. It appears that his former partner and his daughter were also in contact about organising support for him during this time. He was turned away from a private hospital for not having a referral and was instead taken to his GP, ultimately "*[his daughter] and family members kept in contact with him via text and phone calls and he promised [his daughter] that he would inform her if he had any further suicidal thoughts.*" The man in this case was comfortable discussing his emotions with his family, and they in turn were able to provide support. Case type five explores the role of good men in responses to communications of intent

Reconstructed case type five

Rob is in his mid-forties. He has been divorced about a year and is not coping well. During the end of his marriage. Rob made an appointment with his GP to discuss how he was feeling. He was starting to lose interest in work and friends, and this worried him. His GP recommended he start seeing a psychologist, Dr Davis, who he continued to see up until his death. Dr Davis reported to the coroner, that Rob had mentioned he was suicidal on a few occasions. They discussed the impact this would have on his family, he had young grandkids who he adored. He was also helping his daughter financially while she looked for work. Dr Davis and Rob made a suicide safety plan, which involved Rob's family being aware of his illness. His family were very accommodating. He called his sister one day saying he was suicidal. She called police, who went to his house. Rob was taken to hospital where he stayed as a voluntary patient for the night and was released into the care of his family and psychologist. He died by suicide a week later.

Case type five is a counterpoint to responses to communications of intent characteristic of the previous two themes. The role of masculinity in service usage was explored by O'Brien et al. (2005) who interviewed men who sought help for various illnesses. They found that some depressed men sought help "in spite of the perceived consequences to their masculinity" because they "felt a responsibility towards their wives to seek help" (O'Brien et al., 2005:512). A similar pattern was identified in cases of good men. As the case of Rob illustrates, like the suicidal men he is based upon, his daughter's dependence on him played a part in why he did not suicide.

A key finding from the analysis of good men is that they received the best responses of all types of masculinity identified in this research. As the case type of Rob shows, suicidal good men were well supported by their family, friends, and partners. Rob, and the men he is based on were not intimidating to their loved ones and were not acting in a way that impeded recipients' attempts to help. The responses he received were a reflection of his different interpretation of masculinity. Rob's case shows that for some men communicating intent, receiving and engaging with help may feed into their experience of hegemonic masculinity: a man who is open to being supported, to receive treatment, and to continue to be depended on by those who need him.

Many of the good men were also proactive in their treatment, initially seeking it out on their own, as Rob did, reflecting a finding by Noone and Stephens (2008:720-721), that some men who utilised health services performed masculine honour by educating themselves about their illnesses and mastering it. Noone and Stephens (2008:720) described this type of masculine identity as the 'lay expert' position. In a bid to regain control over their circumstances, these men become 'lay experts' about their diagnoses allowing them to feel equal to their health providers, instead of passive patients. A pattern of trying to understand and manage their mental illness, suicidality and themselves was evident in the frequent use of formal services by suicidal 'good' men.

Discussion: qualitative phase

With a focus on masculinities, the qualitative phase of the sociological autopsy has indicated that gender norms play a major role in responses to communications of intent to suicide.

The most significant finding is the levels of adherence to traditional forms of masculinities appearing to be associated with the level of response received. The role of 'traditional' notions of masculinities and their effects on men's health is well documented (see Courtenay, 2003). Men who tend to enact more traditional masculine behaviours, like those identified in the big build, may be less likely to ask for help when they need it for fear of emasculation or subordination (Courtenay, 2000; Courtenay, 2003). It would appear that the performance of masculinities and power provides a critical context for how recipients feel they can respond to a communication of intent. Recipients of communications of intent in studies by Owens et al. (2011:6) and Player et al. (2015:6-7) feared responding the wrong way would cause the suicidal person to feel alienated. Recipients in this study appeared to respond in a similar way, but with the application of theories of masculinities we are able to deduce a potential explanation as to why. Men who are feeling suicidal may be compensating for their emotionality by acting in hyper-masculine ways to deal with their distress ('the big build'), which can cause anti-social behaviours making it difficult for recipients to provide support without furthering the men's experience of emasculation and possibly increasing his suicidality.

Tensions between expectations of gender roles, of traditional femininity and traditional masculinity, were evident in many responses made by female intimate partners, resulting in dismissals, except for 'good men'. Attempts to re-dominate and control female intimate partners through threats to suicide frequently resulted in a dismissal. Friends and family members were slightly more likely to intervene following a communication of intent in most men, but again, good men who made their communication of intent to a friend or family member were the most likely to receive organisational interventions. There is evidence that some men equate asking for, and needing help as a sign of 'weakness' (Cleary, 2005; Courtenay, 2000), and the role of 'patient' with feminised passivity (Noone and Stephens, 2008). A man who fails to live up to hegemonic expectations of masculinity, for example, no longer being employed and in a relationship, may experience a violent and or subordinated status. Some men try to mitigate the loss of hegemonic-identity through a hyper-masculine performance, in some cases this includes violence against other people, to compensate for their subordinate 'help-needing' status and project a more hegemonic, independent identity (Pyke, 1996:532). The men who did not engage in these types of performances were more likely to receive organisational-level help, likely due to their support networks being able to provide support without fear that he would become either violent or experience further emasculation.

Conclusion: qualitative phase

This analysis has provided a context to why recipients of communications of intent responded in the ways they did as outlined in the quantitative section. This section has also shown the utility of applying gender theory to case types of suicide in order to better understand the gender paradox of suicide. We have shown that types of masculinities are associated with responses outside formal health services, which may contribute to the higher rate of suicide by men. This chapter has indicated that gender norms play an integral role in responses to communications of intent to suicide. The following chapter will discuss the overall picture of the role of gendered norms in responses to communications of intent.

Chapter Five
Conclusion

This thesis has argued that gender norms play a role in responses to communications of intent, first through quantitative analyses of all communications of intent in cases of suicide and then through an in-depth qualitative analysis of the role of masculinities in responses to communications of intent from cases identified in the quantitative section. This final chapter will conclude the thesis with an overall analysis of both sections of the sociological autopsy, policy recommendations, limitations of the study, avenues for future research, and a conclusion for the thesis.

Through the application of gender theory and the sociological autopsy method, this thesis has shown that different forms of masculinities and gendered power dynamics need to be considered if we are to understand the possible ways in which people respond to communications of intent. We have also shown that the gendered implications of how communications of intent unfold and are responded to, should be taken into account to further explanations for the gender paradox of suicide. The use of the two-phased sociological autopsy approach has provided a generalisable idea of how communications of intent are made through the quantitative phase, which showed significant differences in how and to whom communications of intent were made among men. Though it would appear from quantitative analysis that there were no significant differences between men and women in responses to communications of intent, the qualitative phase showed the role that violent, subordinate, and rational masculinities played in responses to communications of intent made by suicidal men and provided some context and a potentially different explanation as to why men may die more frequently of suicide than women.

We have shown too that the people who received the communication were associated with particular types of responses. Men who were dismissed following their communication of intent were significantly more likely to have made their communication to an intimate partner or ex-intimate partner than men who received an intervention. The gender dynamics, which were explored in the qualitative section, found that a power struggle is a common theme in responses by intimate and ex-intimate partners. However, when the suicidal men were

invoking rational masculinity to manage their distress, intimate and ex-intimate partners were better able to facilitate organisation-level interventions and thus provide a possible avenue into the formal health system.

This thesis has also provided an alternative narrative to common discourses of male suicidal behaviours in research. In the literature review chapter, we found that applying gender theory to explain suicidal behaviours in men and women is at the forefront of sociological research of suicide. Applying gender theory to communications of intent has not been done previously. By applying gender theory to case types of people who died by suicide informed by cases on the NCIS, we have found a contradiction to common understandings of gendered behaviours as binary between men and women. For example, non-fatal suicidal behaviours are commonly associated with attention-seeking ambivalence and, therefore, femininity (Canetto and Sakinofsky, 1998). Yet, many violent and subordinate men invoked these types of behaviours to control the people around them, indicating a need for these types of behaviours to be understood and considered in policy-related responses to suicidal men. This thesis has also illustrated Scourfield's (2005) argument that suicidology must consider men and women as heterogenous groups with many similarities as well as differences among and between them.

Policy makers need to consider the role of gender in programs that respond to communications of intent to suicide. Similar to Player et al. (2015) we have found that informal relationships are important to suicidal men and women and, like Owen et al. (2012), further education of this population in how to respond is warranted. However, we have also shown the need for a specific consideration of the gendered power dynamics within relationships between suicidal men and their support networks. We have shown that intimate partners are less likely to respond if they have a position of vulnerability, friends are likely to respond to communications of intent, but not necessarily with organisation involvement, and family members, though at times trying to negotiate the masculine performance of the suicidal man, appear to be the most likely to be able to by-pass gendered expectations of men and involve organisational intervention. This is possibly due to the lessened expectations of masculine displays among family than among friends and intimate partners and may also explain why family members were the most common recipients of communications of intent. As with recent changes to policy responses to domestic violence, the main area of potential here is through service responses cutting though these power dynamics.

The formal service system played a marginal role in cases of violent and subordinate men compared to rational men. This may be because rational men presented as depressed and sought help, behaviours more in line with classic suicidality, and allowed for personal networks and service providers to attempt to adequately respond. A policy program that targets this type of 'responsible' and reasonable masculinity, that can still feed into the provider role, and calls on men to take responsibility of their mental health for their loved ones, may be a helpful avenue for suicide prevention in men.

When organisations were involved the support appeared to be insufficient in many cases. Many families described being rebuffed from formal mental health services for not having a referral during an acute suicidal episode of a loved one. It may be beneficial to those supporting someone who is in (and those who are having) a suicidal crisis for the referral system to be reviewed during mental health crises. Perhaps referrals could be made by someone in-house during a crisis, instead of turning desperate people away to go and get the necessary paperwork. The findings here suggest that there is a long way to go in service responses to suicidal crises and adds to the mounting evidence, such as that found by C.R.E.S.P (2015) and recently reported by *The Guardian* (Murphy, 2019), that formal health services may be causing harm to suicidal patients and that these allegations must be urgently addressed.

Furthermore, it could be argued that all responses were insufficient in every case, due to ultimately each case resulting in suicide, which highlights some limitations of this thesis. One such limitation pertains to why many men and women still died by suicide despite organisational intervention and/or powerful displays of support from their social networks. These cases hint at the complexity of the relationship between mental illness and gender norms which we can highlight to some extent with a sociological autopsy but can much less explain *why* they still took their own lives. Answers to this question can only be guessed at given the limitations of the documents available, which do not take us into the mind of the men at the time. Instead what they can show us, is what kinds if responses do work (even if only for a short time) and which types need better resources to facilitate recovery from suicidality.

There were some other limitations to this thesis that must be considered. A larger sample of women is needed to properly compare differences in communications of intent and responses, and a similar study is needed that focuses specifically on femininities. Also, it is unknown how many people communicated intent to suicide in 2014 and survived. Future research ought to survey people who use formal health services, particularly men in hospitals for suicidality, to understand how they got there. It is unknown, for example, whether men who express suicidal intent to intimate partners or organisations are more likely to survive and therefore not appearing in this dataset.

Future research should focus therefore, on the variety of identities of people who die by suicide as well as include larger samples of women and focus on the role of femininity on responses to communications of intent to suicide. Furthermore, the race, sexuality, cultural background, class, and physical abilities of the people who died by suicide were rarely mentioned in coronial files and were therefore not able to be tested in responses to communications of intent. Some cases mentioned physical and mental illnesses but this likely reflects the current understandings of why someone might suicide due to the function of coronial files being to gather evidence for a decision on whether a suicide occurred. Importantly, cases within the NCIS do not ordinarily identify cases' Indigeneity which needs to specifically be applied for and searched on the system[11]. Unless the case file mentioned Indigeneity, which few did, we could not determine which cases identified as Indigenous. The role of violence and types of dismissals should also be considered as variables to be tested in larger quantitative studies into responses to communications of intent.

Finally, this thesis has shown that gender norms play an important role in how people respond to communications of intent to suicide. We showed that the more a man adhered to particular traditional notions of masculinity, such as stoicism, the less likely he was to receive organisational help. These masculinities may explain why men die more frequently of suicide than women and need to be examined further. These gendered implications should be addressed in policy aimed at getting suicidal men support. Furthermore, we have shown a sad reality: though the many respondents involved organisational interventions following a communication of intent, the organisational intervention itself appears to be insufficient, in

[11] Indigenous Origin is not generally identifiable for a range of cultural reasons. We did not apply to have this field supplied to us because of the context of Indigenous suicide is outside the scope of this thesis. The NCIS does provide identification of Indigenous cases upon request and approval.

that these people still died often within 24 hours of the communication, a finding that needs to be urgently addressed if we are to prevent future suicides.

References

Atkinson J.M. (1978) *Discovering Suicide: Studies in the Social Organisation of Sudden Death,* Pittsburgh: University of Pittsburgh Press.

Australian Bureau of Statistics. (2016) *3303.0 - Causes of Death, Australia, 2014*. Available at: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2014~Main%20Features~Key%20Characteristics~10054.

Australian Bureau of Statistics (ABS). (2019a) *3303.0 Causes of Death, Australia, 2018: Table 11.5 Intentional self-harm by mechanism, number of deaths by sex, 2009-2018* Available at: https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02018?OpenDocument.

Australian Bureau of Statistics (ABS). (2019b) *Causes of Death, Australia, 2018*. Available at: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3.

Australian Institute of Health and Welfare (AIHW). (2018) Mental health services - in brief. Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW), Harrison J.E. and Henley G. (2014) Suicide and hospitalised self-harm in Australia: trends and analysis. *Injury research and statistics.* Canberra, Australian Capital Territory: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare (AIHW) and Pointer S.C. (2018) Trends in hospitalised injury, Australia 1999-00 to 2014-2015. *Injury research and statistics.* Canberra: AIHW.

Beautrais A.L. (2003) 'Suicide and serious suicide attempts in youth: a multiple-group comparison study'. *American Journal of Psychiatry* 1601093-1099.

Bleeser N., Hansford H., Griffiths O., et al. (2010) The hidden toll: suicide in Australia. Pailiament House, Canberra: Senate Committee Secretariat.

Braun V. and Clarke V. (2006) 'Using thematic analysis in psychology'. *Qualitative Research in Psychology* 3:2, 77-101.

Brownhill S., Wilhelm K., Barclay L., et al. (2005) ''Big build': hidden depression in men'. *Australian and New Zealand Journal of Psychiatry* 39921-931.

Butler J. (1993) *Bodies that Matter: on the Discursive Limits of "Sex",* New York: Routledge.

Butler J. (2006) *Gender Trouble: Feminism and the Subversion of Identity,* New York: Routledge Classics.

Canetto S.S. (1991) 'Gender roles, suicide attempts, and substance abuse'. *The Journal of Psychology* 125:6, 605-620.

Canetto S.S. (1997a) Gender and suicidal behaviour: theories and evidence. In: Maris RW, Silverman MM and Canetto SS (eds) *Review of Suicidology.* New York: Guilford, 138-167.

Canetto S.S. (1997b) 'Meanings of gender and suicidal behavior during adolescence'. *Suicide and Life-Threatening Behavior* 27:4, 339-351.

Canetto S.S. (2008) 'Women and suicidal behavior: a cultural analysis'. *American Journal of Orthopsychiatry* 78:2, 259-266.

Canetto S.S. and Cleary A. (2012) 'Men, masculinities and suicidal behaviour'. *Social Science & Medicine* 74461-465.
Canetto S.S. and Lester D. (1998) 'Gender, culture, and suicidal behaviour'. *Transcultural Psychiatry* 35:2, 163-190.
Canetto S.S. and Sakinofsky I. (1998) 'The gender paradox in suicide'. *Suicide and Life-Threatening Behavior* 28:1, 1-23.
Carpenter B., Tait G., Quadrelli C., et al. (2016) 'Investigating death: the emotional and cultural challenges for police'. *Policing and Society* 26:6, 698-712.
Carpenter B., Tait G., Stobbs N., et al. (2015) 'When coroners care too much: therapeutic jurisprudence and suicide findings'. *Journal of Judicial Administration* 24:3, 172-183.
Chrisler J.C. and McHugh M.C. (2018) Feminist critiques of psychology. In: Travis CB and White JW (eds) *APA Handbook of the Psychology of Women: History Theory, and Battlegrounds.* USA: American Psychological Association, 71-89.
Cleary A. (2005) 'Death rather than disclosure: struggling to be a real man'. *Irish Journal of Sociology* 14:2, 155-176.
Connell R.W. (1987) *Gender and Power,* North Sydney: Allen and Unwin.
Connell R.W. (2005) *Masculinities*: Polity.
Cottrell D. (2013) 'Engaging young people in treatment after self-harm'. *Archives of Disease in Childhood* 98:10, 749-750.
Courtenay W.H. (2000) 'Contructions of masculinity and their influence on men's well-being: a theory of gender and health'. *Social Science & Medicine* 501385-1401.
Courtenay W.H. (2003) 'Key determinants of health and well-being of men and boys'. *International Journal of Men's Health* 2:1, 1-30.
Cox P. (2016) Violence against women: additional analysis of the Australian Bureau of Statistics Personal Safety Survey, 2012. Sydney: ANROWS.
Cravens J.D., Whiting J.B. and Aamar R.O. (2015) 'Why I stayed/left: an analysis of voices of intimate partner violence on social media'. *Contemporary Family Therapy* 37372-385.
De Leo D., Cerin E., Spathonis K., et al. (2005) 'Lifetime risk of suicide ideation and attempts in an Australian community: prevalence, suicidal process, and help-seeking behaviour'. *Journal of Affective Disorders* 86215-224.
Denning D.G., Conwell Y., King D., et al. (2000) 'Method choice, intent, and gender in completed suicide'. *Suicide and Life-Threatening Behavior* 30:3, 282-288.
Denzin N.K. and Lincoln Y.S. (2005) Introduction: disciplining the practice of qualitative research. In: Denzin NK and Lincoln YS (eds) *The SAGE Handbook of Qualitative Research.* 3rd ed. Thousand Oaks: Sage Publications.
Douglas J. (1967) *The Social Meanings of Suicide,* New Jersey: Princeton University Press.
Durkheim E. ([1893]1969) *The division of labor in society,* Glencoe, Illinois: Free Press.
Durkheim E. ([1897]1951) *Suicide: a study in sociology,* New York: Free Press.
Fincham B., Langer S., Scourfield J., et al. (2011) *Understanding Suicide: A Sociological Autopsy,* UK: Palgrave MacMillan.
Fletcher R.F. (1999) 'The process of constant observation: perspectives of staff and suicidal patients.'. *Journal of Psychiatric and Mental Health Nursing* 69-14.
Flink A. and Paavilainen E. (2008) 'Violent behavior of men in their intimate relationships, as they expereince it'. *American Journal of Men's Health* 2:3, 244-253.
Fu K., Cheng Q., Wong P.W.C., et al. (2013) 'Responses to a Self-Presented Suicide Attempt in Social Media: A Social Network Analysis'. *Crisis* 34:6, 406-412.
Hengeveld M.W., Kerkhof A.J.F.M. and van der Wal A. (1988) 'Evaluation of psychiatric consultations with suicide attempters'. *Acta Psychiatrica Scandinavica* 77283-289.

Hill N.T.M., Halliday L. and Reavley N.J. (2017) Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings. Sydney: Black Dog Institute.
Hopkins C. (2002) ‘‘But what about the really ill, poorly people?’ (An ethnographic study into what it means to nurses on medical admissions units to have people who have harmed themselves as their patients)’. *Journal of Psychiatric and Mental Health Nursing* 9147-154.
IBM corporation. (2016) IBM SPSS Statistics for Windows. 24 ed. Armonk, NY: IBM Corp.
Isometsä E. (2001) ‘Psychological autopsy studies -a review.’. *European Psychiatry* 16:7, 379-385.
Jaworski K. (2003) ‘Suicide and gender: reading suicide through Butler’s notion of performativity’. *Journal of Australian Studies* 27:76, 137-146.
Jaworski K. (2010) ‘The gender-ing of suicide’. *Australian Feminist Studies* 25:63.
Kanchan T. and Menezes R.G. (2009) ‘Methods of choice in completed suicides: gender differences and review of the literature’. *Journal of Forensic Science* 54:4, 938-942.
Kimmel M.S. (1997) Masculinity as homophobia: Fear, shame and silence in the construction of gender identity. In: Gergen MM and Davis SN (eds) *Toward a New Psychology of Gender.* Florence, KY, US: Taylor and Francis/Routledge.
Kjølseth I. and Ekeberg Ø. (2012) ‘When elderly people give warning of suicide’. *International Psychogeriatrics* 24:9, 1393-1401.
Kunde L., Kolves K., Kelly B., et al. (2018) ‘“The Masks We Wear”: a qualitative study of suicide in Australian farmers’. *Journal of Rural Health* 34:3, 254-262.
Labovitz S. (1986) ‘Criteria for selecting a significance level: a note on the sacredness of 0.05’. *The American Sociologist* 3200-222.
Latakiene J., Skruibis P., Dadasev S., et al. (2016) ‘“They Don’t Take It Seriously”: Perceived Reactions of Surrounding People to Suicide Communication’. *Illness, Crisis & Loss* 24:3, 123-136.
McCormick C. (2007) Empiricism. In: Ritzer G (ed) *The Blackwell Encylopedia of Sociology.* Victoria, Australia: Blackwell Publishing Ltd.
McPhedran S. and De Leo D. (2013) ‘Miseries suffered, unvoiced, unknown? Communication of suicidal intent by men in “rural” Queensland, Australia’. *Suicide and Life-Threatening Behavior* 43:6, 589-597.
Milner A., Maheen H., Currier D., et al. (2017) ‘Male suicide among construction workers in Australia: a qualitative analysis of the major stressors precipitating death’. *BMC Public Health* 17:584, 1-9.
Murphy K. (2019) Scott Morrison’s suicide prevention adviser says mental health system may increase risk of self-harm. *The Guardian.* Sydney: The Guardian News and Media Ltd.
NHMRC Centre of Research Excellence in Suicide Prevention (C.R.E.S.P). (2015) Care after a suicide attempt. Sydney: NHMRC Centre of Research Excellence in Suicide Prevention (C.R.E.S.P), Black Dog Institute.
Noone J.H. and Stephens C. (2008) ‘Men, masculine identities, and health care utilisation’. *Sociology of Health and Illness* 30:5, 711-725.
O’Brien R., Hunt K. and Hart G. (2005) ‘‘It’s caveman stuff, but that is to a certain extent how guys still operate’: men’s accounts of masculinity and help seeking’. *Social Science & Medicine* 61503-516.
Orbach I., Gilboa-Schechtman E., Ofek H., et al. (2007) ‘A chronological perspective in suicide - the last days of life’. *Death Studies* 31909-932.

Owen G., Belam J., Lambert H., et al. (2012) 'Suicide communication events: lay interpretation of the communication of suicidal ideation and intent'. *Social Science & Medicine* 75.
Owens C., Owen G., Belam J., et al. (2011) 'Recognising and responding to suicidal crisis within family and social networks: qualitative study'. *British Medical Journal* 343:d5801.
Parliament of Queensland. (2012) Domestic and Family Violence Protection Act 2012. Brisbane, Queensland: Parliament of Queensland,.
Perceval M., Kolves K., Ross V., et al. (2018) 'Environmental factors and suicide in Australian farmers: a qualitative study'. *Archives of Environmental & Occupational Health* 1-8.
Player M., Proudfoot J., Fogarty A., et al. (2015) 'What interrupts suicide attempts in men: a qualitative study'. *PLoS ONE* 10:6.
Pompili M., Belvederi Murri M., Patti S., et al. (2016) 'The communication of suicidal intentions: a meta analysis'. *Psychological Medicine* 462239-2253.
Potts B., Kolves K., O'Gorman J., et al. (2016) Suicide in Queensland: mortality rates and related data 2011-2013. Griffith University: Australian Institute for Suicide Research and Prevention
Pyke K.D. (1996) 'Clas-based masculinities the interdependence of gender, class, and interpersonal power'. *Gender & Society* 10:5, 527-549.
Rasmussen M.L., Dieserud G., Dyregov K., et al. (2014) 'Warning signs of suicide in young men'. *Nordic Psychology* 66:3, 153-167.
Reavley N.J. and Jorm A.F. (2011) 'Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey of Mental Health Literacy and Stigma'. *Australian & New Zeland Journal of Psychiatry* 451086-1093.
Ridgeway C.L. (2009) 'Framed before we know it: how gender shapes social relations'. *Gender & Society* 23:2, 145-160.
Risman B.J. (2004) 'Gender as a social structure: theory wrestling with activism'. *Gender & Society* 18:4, 429-450.
Risman B.J. (2009) 'From doing to undoing: gender as we know it'. *Gender & Society* 23:1, 81-84.
Robins E., Gassner S., Kayes J., et al. (1959) 'The communication of suicidal intent: a study of 134 consecutive cases of successful (completed) suicide'. *American Journal of Psychiatry* 115:724-733.
Rudestam K.E. (1971) 'Stockholm and Los Angeles: a cross-cultural study of the communication of suicidal intent'. *Journal of Consulting and Criminal Psychology* 36:1, 82-90.
Rugkhla P. (2011) Women and suicide. *Gender Impact Assessent.* Melbourne, Victoria: Women's Helath Victoria.
Samuelsson M., Wiklander M., M. A., et al. (2000) 'Psychiatric care as seen by the attempted suicide patient'. *Journal of Advanced Nursing* 32:3, 635-643.
Saunders K.E.A., Hawton K., Fortune S., et al. (2012) 'Attitudes and knowledge of clinical staff regarding people who self-harm: a systematic review'. *Journal of Affective Disorders* 139:3, 205-216.
Scourfield J. (2005) 'Suicidal Masculinities'. *Sociological Research ONline* 10:2.
Scourfield J. and Evans R.J. (2015) 'Why might men be more at risk of suicide after a relationship breakdown? Sociological insights'. *American Journal of Men's Health* 9:5, 380-384.
Scourfield J., Fincham B., Langer S., et al. (2012) 'Sociological autopsy: an integrated approach to the study of suicide in men'. *Social Science & Medicine* 74466-473.

Shiner M., Scourfield J., Fincham B., et al. (2009) ‘When things fall apart: Gender and suicide across the life-course’. *Social Science & Medicine* 69738-746.
Strike C., Rhodes A.E., Bergmans Y., et al. (2006) ‘Fragmented pathways to care: the experiences of suicidal men’. *Crisis* 27:1, 31-38.
Tait G. and Carpenter B. (2013) ‘Suicide and the therapeutic coroner: Inquests, governance and the grieving family’. *International Journal for Crime, Justice and Social Democracy* 2:3, 92-104.
Tait G. and Carpenter B. (2015) ‘Suicide, statistics and the coroner: A comparative study of death investigations’. *Journal of Sociology* 51:3, 553-565.
Taylor T.L., Hawton K., Fortune S., et al. (2009) ‘Attitudes towards clinical services among people who self-harm: systematic review’. *The British Journal of Criminology* 194:2, 104-110.
Timmermans S. (2005) ‘Suicide determination and the professional authority of medical examiners’. *American Sociological Review* 70:2, 311-333.
West C. and Zimmerman D.H. (1987) ‘Doing gender’. *Gender & Society* 1111-116.
Westerlund M., Hadlaczky G. and Wasserman D. (2015) ‘Case study of posts before and after a suicide on a Swedish internet forum’. *The British Journal of Psychology* 207476-482.
Wolk-Wasserman D. (1986) ‘Suicidal communication of persons attempting suicide and responses of significant others’. *Acta Psychiatrica Scandinavia* 73481-499.

Appendix – Ethcis Clearance Forms (pages 77-78) removed from Open Access version as they may contain sensitive/confidential content.