Masculinities and suicide

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Masculinities and suicide: unsettling 'talk' as a response to suicide in men

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Abstract

An increasingly common way that high rates of male suicide are understood is via men's ostensibly poorer abilities to talk about – and more generally seek help for – problems in general, and emotional problems specifically. This has led to the development of public mental health campaigns which urge men to 'speak up' more often about the problems they face. I argue that both the initial claim, and the enactment of this claim in public mental health campaigns, is problematic, resting on simplistic assumptions about men and gender difference, and serving to detract attention from structural drivers of suicide. Drawing on a narrative analysis of in-depth interviews with ten men who had self-harmed, thought about, or attempted suicide, this paper focuses attention on the content and contexts of 'talk'. I argue that public health campaigns promoting 'talk' in response to male suicide neglect the interpersonal and structural contexts in which talk occurs, including considerations of power and structural inequalities.

Keywords: gender, masculinities, suicide, emotion, stigma

Introduction

> "… a lot of young men are just soldiering on regardless and swallowing their feelings and that comes with its own unique set of challenges, **as evidenced by the number of men in the UK who reach the stage where they take their own life.** We felt that if we could inspire men to open up and discuss their worries we could help to create a culture where it's OK for men to ask for the help they need" (Natasha Devon, UK-based mental health campaigner, quoted in Telegraph Men, 2015, emphasis added).

Men are more likely to kill themselves than women: in the UK, the US, Australia and other high-income countries, the gender ratio is similar, with around three times more men than women dying by suicide (Cleary, 2019; WHO, 2014). In recent years, public mental health campaigns in these countries have targeted men, and in doing so, draw connections between men's suicide, and gendered emotional and communication practices. The quote from Natasha Devon, above, ties men's enactment of suicide to gendered difficulties they may face communicating about problems or feelings. Ostensibly, such campaigns are encouraging – suggesting suicide is recognised as a social (rather than purely psychological, or psychiatric) issue, with gender framed as a social production, one that can be recognised and engaged with (Seidler et al., 2017; White et al., 2016). However, in this paper I argue that these approaches rest on problematic assumptions about men, and male/female difference, and that they minimise structural inequalities which contribute to suicide.

The suggestion that men *as a group* are less able to talk about their emotions or problems with others reflects a simplistic interpretation of the way in which gender shapes experiences of and responses to distress (Galasiński, 2004). Firstly, and perhaps most obviously, this approach can result in diversities among men being minimised, with *all men* being framed as facing similar challenges (Cleary, 2019). Scholarship addressing gender differences in help-seeking and communication about emotions indicates that there are significant diversities

among men in each regard (Cleary, 2019; Farrimond, 2012; Galasiński, 2004; McQueen, 2017; O'Brien et al., 2005, Seidler et al., 2017).

Focusing on apparent difficulties faced by men in communicating about their feelings also fails to attend to the *contexts* in which 'emotional talk' might occur, framing any expression of emotion as 'good'. Recent critical interventions by de Boise and Hearn (2017) urge caution in assuming that expressions of emotions by men are always positive, or even benign. Indeed, anger, rage, and jealousy are emotional, but can cause harm to others. De Boise and Hearn note that communicating about problems and emotions may in fact occur in ways which further entrench inequalities in relation to gender, race, class and dis/ability (see also River & Flood 2021 for further elaboration on this point).

In this paper I seek to unsettle commonly held assumptions about men, suicide and the centrality of 'talk' to public mental health campaigns designed to respond to men's suicide. I draw on an exploratory interview study with ten UK-based men who had self-harmed, attempted, or planned suicide. Drawing on a narrative-informed analysis, I show how these interview accounts both affirm and trouble the frequently alleged link between men's suicide, and practices of emotional communication. Before introducing the study, I discuss in more detail how men's emotions and communicative practices are drawn out in existing research.

Men and suicide

Explanations for the gap between male and female suicides are various, and many relate to the 'doing' of gender in culturally and socially proscribed ways (Canetto & Sakinofsky, 1998; Cleary 2019; Jaworski, 2014; Payne et al., 2008). In some analyses this applies to immediate aspects of the practice, such as methods choice, with men more likely to use 'lethal' means (such as firearms and hanging). Scholars have related this to men's fear of 'failure' and to the association of non-fatal self-harm with women (and with failure) (Canetto

& Sakinofsky, 1998; Oliffe et al., 2012). Thus, gender is said to infuse the practice of suicide/self-harm, and in doing so shapes the outcome (Jaworski, 2014).

A focus on communication styles addresses a more upstream perspective, suggesting that compared to women, men – guided by dominant masculine ideals – are more likely to prize being 'strong and silent' (Courtenay, 2000; Oliffe et al., 2017). This results in lower rates of help-seeking (Mallon et al., 2019; Seidler et al., 2017) and, more informally, a tendency to avoid talking about emotions, or acknowledging problems. (Cleary, 2012; Möller-Leimkühler, 2003; Oliffe et al., 2017; Payne et al., 2008). Such arguments rest on an understanding that problems will inevitably intensify, and if not given a proper outlet, emotions may 'build up' resulting in suicide (Brownhill et al., 2005; Oliffe et al. 2017).

Recent qualitative studies with men shed some light on the nuanced and complex ways in which relational contexts, along with gendered expectations (of both men and those around them) may shape men's ability to feel connected to those around them (Oliffe et al. 2017; Apesoa-Varano et al. 2018). These studies highlight the quality and nature of relationships rather than 'talk' per se in contributing to or ameliorating men's isolation, distress and suicidality. Apesoa-Varano et al., for instance, found older men who described having greater struggles with suicidal thoughts tended to reference family relationships where they felt ignored and not given the respect that 'should' be accorded to men. In each case, shame, isolation and unfulfilling or even damaging relational contexts were associated with men's distress.

These recent studies provide insight into the nuanced ways in which men's emotional and social lives intersect with gendered cultural expectations of how men should be, shaping experiences with suicide. Implicitly, these studies trouble exhortations that men should 'speak up' about their problems (Who to? With what effects?). However, a focus on 'talk'

has been subject to limited critical analysis. Building on these emergent insights this paper seeks to 'unsettle' the suggestion – embedded in many public mental health campaigns – that if men only talked more, they would die by suicide less. As I discuss below, while men in my study did affirm the difficulty and importance of 'talking', a critical analysis of their accounts points also to the importance of the unsettling content of what men might say, and the challenges that contexts – interpersonal and structural – pose to 'talk' as a focus of suicide prevention for men.

Methods

This study set out to explore how narratives of alcohol use, mental health experiences, self-harm and suicide were articulated by men with diverse experiences with these practices (see Chandler and Nugent 2016). Both previous self-harm and alcohol-use are highlighted as a risk factors for suicide (Cleary, 2012; Möller-Leimkühler, 2003). However, there had been limited qualitative exploration of the *meanings* that alcohol use, mental health and self-harm have for men who are at high risk of suicide nor the complex ways in which these practices may intertwine. The study was assessed and approved by the University of Edinburgh CPHS Ethics Review Committee (2015).

Participants were recruited via a community-based mental health organisation in Scotland, UK. The inclusion criteria were that men be aged between 35-54 ('mid-life'), with experience of self-harm or suicidal thoughts. Self-harm was deliberately defined broadly, to include self-poisoning, self-injuries, or acts framed as 'attempted suicide'. I worked with the recruiting organisation to ensure participants had a range of experiences with alcohol. Recruitment was straightforward, with the target of ten interviews reached within six months during 2015.

Nine of the men who took part were aged between 35 and 54; one man was aged 61 but was included as he was keen to take part and fulfilled all other inclusion criteria. Participants were

white, all but two were unemployed, and all described some degree of socioeconomic difficulty. All but one participant presented as heterosexual, and all were cis-gendered. Participants were supported by the recruiting organisation, though the nature of this support varied from one-to-one counselling, to attending social events or projects designed to promote social inclusion and belonging. As such, the sample is clearly biased towards men who are involved with services – they had, in some way or another 'sought' or 'received' help for mental health or alcohol use problems. Nonetheless, the interviews provided rich, detailed accounts of different ways in which a group of men who have self-harmed might make sense of mental health experiences, emotional communication, and gender identity.

The interviews took the form of 'life-story' interviews. These were deliberately unstructured, men were asked to talk about what they wanted to, start where they wanted to. They were given the opportunity to use a 'lifegrid' to do this, and some chose to do so. Others were clearer that they had stories they could tell without the need to use the grid. Participants were aware of the focus of the research and most tailored their accounts towards alcohol use, or mental health experiences. On reflection, some participants would have appreciated a more structured approach, with at least some set questions. Most interviews progressed easily, with good rapport developed. Interviews were held in private rooms in community centres, places where men felt comfortable and were used to engaging in 'talk' about their experiences. Interview rapport was likely helped by my taking an informal and non-judgemental approach. Some indicated they had expected a researcher to appear wearing a suit and were relieved to find me more approachable.

Analysis drew on narrative and thematic approaches (Riessman, 2008). The interviews were digitally recorded and transcribed verbatim by a professional transcription service, checked and pseudonymised. Transcripts were read multiple times by myself and a research assistant (Chandler and Nugent 2016). This process generated a number of themes, some of which

were subject to further analysis. Coding, generation and refinement of themes was an iterative process, working between themes, existing research and relevant social theory (Tavory & Timmermans, 2014). The analysis presented in this paper addresses men's accounts of communication about mental health experiences in general, and suicide/self-harm in particular. Throughout the analysis I take a clear position in relation to the status of these accounts as situated, partial, interactive performances – co-created with me in an interview setting (Holstein & Gubrium, 1995).

Findings

Maintaining silence

The idea that men as a group find it hard to talk about problems or emotions was routinely raised by interviewees. Participant's narratives ranged from personal accounts describing in detail how they had remained 'silent' for many years about mental health struggles, to more general claims about men.

Tom spoke at length of deep cultural imperatives among men to be 'strong' and not share emotions or feelings with others:

> And like I say, for men, we don't talk about that kind of stuff. We'll say aye, we love you and all that kind of thing, but nothing else. You don't talk about your feelings and emotions and all that kind of thing. That's for women, isn't it? Man up, grow a set of balls and all that kind of thing. So you bottle it up and bottle it up and then it's obviously going to have a detrimental effect to your health, isn't it? (Tom)

Tom's account drew on widely-circulating phrases which produce and reaffirm a gender difference between men and women – with women associated clearly with 'talking about feelings and emotions' – to be a man, 'you' need to avoid such talk, 'bottle it up' (keep feelings and emotions inside). Tom is clear that such an approach is ultimately detrimental to

men's health – framing this as 'obvious' in a way which clearly enrols the interviewer in a shared understanding of both what men 'are like' and that this is a situation which is ultimately unhelpful.

A common narrative across most interviews was a story of many years of 'suffering in silence' – experiencing distress, depression, anxiety, and/or suicidal thoughts, but keeping these feelings private, telling no-one. This finding resonates strongly with existing research (Cleary, 2012; Oliffe et al., 2017), and the conclusion of some of the interviewees mirrored findings in research that this silence can be attributed to masculine expectations about emotional reticence.

> I think for a guy to admit there's something wrong, although it's not, I think they find it as an admission of weaknesses. Guys aren't meant to be like that, they're supposed to be tough and strong. If half the guys would just learn to speak about it and speak up, I think the problem wouldn't be as bad as it is, if it's caught early enough. (Stevie)

Stevie's account of his own trajectory towards 'help-seeking' emphasised the many years he spent 'self-medicating' and managing poor mental health alone, with alcohol, before reaching a point of significant distress and presenting at services who – he wryly noted – turned him away because he was drunk.

Benefitting from talk

Niall, following a common narrative arc, spoke of staying silent about struggles with depression, anxiety and alcohol use over many years. Niall's account emphasised that despite attending a range of services (often in moments of crisis), he had always struggled to 'talk' in these spaces. Only recently did he indicate he had begun to be able to 'talk' effectively about his problems.

> I've actually been going to the guy for four years and I've just started to talk about the really bad things for six months. That's the only way you can do it. […] And you can…he's good. He's a good listener. He's got a good pair of ears. But he tells me things what to do and how to change your mind about how to do things. And it works. It works. (Niall)

Niall's account emphasised the important role of 'talking' in supporting his current ability to live with depression, anxiety, and 'alcoholism'. However, Niall's overall narrative arc indicated that his ability to benefit from such 'talk' was only possible due to some fairly atypical circumstances. A previous job in the armed services, along with involvement in the criminal justice system, had combined to facilitate access to long-term psychological therapy that would have otherwise been extremely difficult to access both in terms of finances, but also in terms of Niall's own comfort with 'talking'. His account suggested that only after 3.5 years did the 'talk' happening in his weekly therapy begin to attend to the 'really bad things'. As such, Niall's account highlights the importance of understanding 'talk' with reference to the *content* of talk and the *contexts* in which it occurs; each of which are shaped by gender, as well as other significant social factors – in this case employment history and socioeconomic class.

Other participants also affirmed the importance of talk in supporting their mental health. Several participants were recruited through a project which offered a men-only space for men experiencing distress, along with the input of a dedicated support worker. This was spoken of highly by participants.

> [worker] just creates a safe place to be, with a group of men. And you realise that, you know, where you can be yourself. (Martin)

Although sharing stories and talking were identified by some as important, the value of the space and 'being alongside' others was also noted, as well as the ability of a particular worker to create a 'safe place to be'. These accounts resonate with calls in some existing literature and men's health campaigns for the creation of more 'male friendly' spaces in which to deliver mental health support. However, as Seidler et al., (2017) note, such approaches can reinforce a view of all men as similar, conversely implying that general mental health services are more accessible to 'all women'.

Benefitting from silence

There were further indications in men's accounts of why and how such silence might be maintained. For instance, the content of men's potential 'talk' may shape what they are able to say. Both Stevie and Tom spoke eloquently of the 'need' for men to 'speak up' more often, or earlier, about their problems in order to stave off future mental health crises (including suicide). However, both also spoke of *ongoing* silences about 'unsayable' experiences, in each case relating to previous problematic substance use and the effects this had on family relationships.

> Because he [father] really didn't talk about these things, you try and spend half your time trying to forget. I think it's probably because you realise how much of an arse you've been. (Stevie)

Thus Stevie, many years after stopping drinking, still spoke of the desire to forget, to not talk with family about how he had been when using alcohol. This silence was said to be maintained within family relationships and supported by Stevie's implied feelings of shame about how he had behaved when drinking. Similarly, Tom recounted ongoing challenges of 'remembering' things he had done when using substances and experiencing suicidal crises.

> … even just today talking about seeing myself in that [situation of suicide plan]. I've never thought about that for a long time and I've never shared it with anyone. This is the first time I've spoken about it. It's weird just to think where I was to where I am now, it's just ridiculous the difference. I mean it's weird because even speaking to people and telling them some of this, and them seeing me the way I am today, you're telling me stories about someone else. But no, that all happened. And probably more, I can't remember all of it. (Tom)

Despite emphasising the importance of 'talk' and the need to speak up more often, and in each case presenting a self in the interview who was able to engage in such talk; both Stevie and Tom indicated ongoing silences: some things were still difficult to speak about, especially to certain people and, it appeared, especially to close family members.

Such partial, situated silence is also reflected in Mike's account. Mike recounted a long history of depression, anxiety and ongoing thoughts of suicide. He was articulate and effusive in discussing his feelings in the interview. Yet his account also framed some of the content of this talk – especially suicide – as unsayable in most other contexts outside of our interview.

> So there is a silence in the…it's embarrassing …to talk about things that's…killing yourself and things like that. You're seen as…I can imagine…because, see, that's what people say to me. … they say, "you think too much". You think that people will think that you're some kind of like pathetic sap. (Mike)

Mike's account speaks to the ongoing stigmatisation of suicide. In his interview he recounted occasions where family members discussed 'others' who had died by suicide in disparaging and negative ways – "it was selfish and bad and rotten and thoughtless and all that stuff", tying this directly to his own feelings of shame about his experiences with suicide.

However, it is important to consider the uses and products of stigma, to think critically about what stigma *does* (Tyler & Slater, 2018). Maintaining silence about suicidal thoughts may act to both navigate stigmatising attitudes which associate suicide with negative attributes *and in doing so* maintain gendered privileges which associate men with strength, stoicism and silent resilience. Men are faced with a doubly powerful disincentive to avoid 'talk' about some feelings and thoughts, and this is irrevocably tied up with men's (relative) privileges, as well as the oppressive movements of stigma.

That men who engage in interviews about mental health and/or suicide are able to talk at length about these experiences, including reflecting on their emotions or feelings, has been identified by numerous other scholars (Cleary, 2012; Galasiński, 2004; Oliffe et al., 2017; River & Flood, 2021). Less often noted is what this might mean for mental health stigma, talk and the maintenance of hierarchies of power. Several participants demonstrated a clear ability to talk, and a willingness to do so in some contexts, but spoke of maintaining silence or privacy about some problems or feelings from intimate partners.

> … the one thing I have spoken to her about is to say […] don't ask me any questions about [particular problems] […] But I always showed an honesty, so I've told her not to .. if I'm away up to my room, don't come up to my room to see if I'm alright. […] I just want to go away and have some peace and be on my own (Mike)

In the intimate space of the family home, Mike's account indicated the construction of careful boundaries between himself and his wife, and a considered silence about many of the problems that were affecting him. His account suggested a high degree of control over the situation, with a focus on maintaining a distance between himself and his wife when it came to his problems.

Contexts of talk

Considering the contexts in which men might talk reflects a crucial modifier to the assumption that men find it hard to talk. As I have shown so far, men did talk at length and with relative ease, about their feelings, emotions and problems in the interview setting. However, it was evident that they did not always find engaging in such talk either easy, or desirable.

Participants spoke of significant challenges in finding appropriate spaces in which to talk or communicate about their problems or feelings. Like others Lewis' account incorporated a long period where he reported staying silent about his feelings despite experiencing several traumatic events. However, Lewis spoke to a recently recognised strong desire to talk about past experiences, and how he felt about them, as a to deal with distress and suicidality – in many ways following the call of public health campaigns to 'reach out' and 'talk more'. However, his attempts to have this desire recognised by statutory mental health services was described as fraught, to say the least.

> And this is what they don't understand either, you know. Like, when I went to the mental health lot, the Crisis team came and spoke to me – "what's triggered it this week, Lewis?", sort of thing. I says, "I have to go back" – "no, we just want to know what happened last week, to make you get into this". I says, "it's the past that's making me feel like this, nothing from last week". And they actually walked out on me, because I said, "it's nothing's triggered this, it's just the way I'm feeling" – "stop dwelling on the past". I says, "I'm not dwelling on the past, the past is still here. And it's affected my future". (Lewis)

Reflecting a similarly difficult relationship with statutory mental health services, Brad indicated that he rejected further involvement with psychologists. Unlike Lewis, Brad framed

this in terms of a rejection of the need or use of 'talking'. However, there were hints in his account that part of the reason Brad felt talking was unhelpful related to the people who were being offered to him to talk with, specifically psychologists and psychiatrists:

> No, I didn't get on with her [psychologist] at all. I didn't find it productive. I still really don't find it productive, talking about all my shit in my life […] I don't see how it's gonna help me now. I've got issues, I know that I've got issues, with my mother, my father, you name it, right. But they're not people that are exactly gonna speak to me about it, you know, and deal with it, all about the issues that I've got with them, and that. I know they're not gonna converse with me, or any of that, so I just accept it, and get on with it (Brad)

These accounts further affirm the importance of contexts and unequal social relationships in shaping the spaces within which men may find it hard to talk.

As shown above, several participants produced well-practiced narratives about the importance of talk to improving mental health, and avoiding suicide, framing men as a group as particularly afflicted by cultural imperatives to silence and emotional reticence. Several emphasised how vital men-only services had been in supporting their own recovery. However, while participants' accounts affirmed this idea, it is important to maintain a critical perspective, and to consider the effects of creating such spaces, and framing them as essential to facilitating men's talk. As we saw in Mike's account, this may have the effect of reaffirming a notion that some topics can only be discussed with other men, and can be withheld from family members and intimate partners.

Further, despite these spaces being valued, there were indications that some topics remained off-limits, unsayable.

> I started to come here and this helped, because you would come in and all the men would get together and you talk about things. Things to help each other while we're…know what I mean. Men talk about things to help their…help, but you never talk about alcohol in here, 'cause everybody had their…all their own wee problems. You never asked anybody. And you…they never asked you. (Niall)

Similarly, Stevie emphasised that stories did not *have* to be shared, and thus even within a 'sharing space' men were able to maintain silence about some issues, if they chose. As such the content of talk about mental health, suicide and other problems that men faced may still be curated to maintain silence about particularly shaming issues: suicide attempts, acts of betrayal against family members, or alcohol use.

These findings raise questions about the imperative to talk more, more often, and sooner that was identified by men in their accounts as important, and which is reified in numerous public mental health campaigns. Is it 'talk' that is important here, or is it – equally – the social bonds that might a) make such talk possible; and b) in themselves offer some amelioration to feelings of suicidality, shame, anxiety or distress (Franklin et al., 2018)?

Discussion: Entrenched structural problems with reifying 'talk' as a response to suicide among men

Across the data it was clear that some things were framed as more 'unsayable' than others. These more unsayable topics might be related to stronger feelings of shame – accusations of sexual assault, theft from family members, attempted ('failed') suicide, ongoing thoughts of death. The shameful nature of such content was not fixed, and given these subjects were articulated in a research interview, were clearly sayable in some contexts. However, participants demonstrated flexibility in when and where they might choose to make visible more shameful aspects of their experiences. Drawing on de Boise and Hearn (2017), I want to

suggest that men's ongoing negotiation of silence in some spaces, with some people, can be understood in terms of maintaining gendered power relations. As such, shame can be seen as productive (Ahmed, 2014; Munt, 2007; Probyn, 2005) – permitting and encouraging silence, which can maintain power, enabling men to continue presenting – to some people and in some contexts – as 'strong and silent'.

This notion is addressed in part by public mental health campaigns which seek to reframe 'talking' or help-seeking for mental health problems as courageous (Oliffe et al., 2012). However, I would argue that there remain powerful and unacknowledged disincentives for men in disclosing their struggles: in some contexts some men may indeed lose status, privilege or power by admitting 'weakness' or shameful aspects of their experiences. Further, in framing men as uniquely challenged in their ability to 'talk' when experiencing mental health difficulties, women are constructed as unaffected by such struggles. Perversely, this may mean that women's articulations of distress are more readily dismissed, while men – when they do seek help – may be taken more seriously, understood to have 'suffered in silence' for far longer (Jaworski 2014).

'Talking' about mental health, emotion, and suicide may occur in ways which maintain inequalities in gender relations. Targeting men's mental health with talk of 'strength' and 'courage' may itself further entrench an association between masculinity, strength and power (Chandler, 2019). For some men talking was not a problem and could be used in ways which sought to enact control in interpersonal relationships. For other men, talking in some contexts was possible, but silence could be retained within interpersonal relationships as a way of enacting control and (masculine, rational) authority.

Public mental health campaigns which encourage men to 'talk' fail to engage with the power dynamics of the contexts in which they might talk – whether within intimate partner

relationships (where women may be relied upon to provide emotional support, and when it is withheld women are framed as 'cold' and 'uncaring') (McQueen, 2017) or in service settings, where the power differences between practitioners and patients may affect the ease or comfort men might feel in making themselves more vulnerable. Men (or indeed any person) who have been involved with a punitive benefits system, criminal justice system, or coercive psychiatric treatment may be unconvinced that a practitioner can 'really hear' or indeed care, about what they have to say.

Finally, talking about problems or emotions does not change the structural, economic, or political conditions which may shape men's distress. Most participants in this study were out of work and receiving benefits. Lack of work, or inability to work, and the shaming of benefits claimants in 21st century austerity Britain shapes and produces distress (Mills, 2018; Scambler, 2018; Tyler & Slater, 2018). Talking and having some social support may help individuals to feel better, but as noted knowingly by several participants, it does not significantly change their housing situation, money worries, or employment status; and it does not generate valuable jobs that can be undertaken by men who have worked in manual labour all their lives but are now physically disabled. As Tyler and Slater (2018) argue, campaigns which focus on 'talking' or 'tackling stigma' in response to mental health are deeply entangled with the interests of neoliberal capitalism, in diverting attention from the social and economic conditions which produce and maintain distress.

Conclusion and Implications

In this paper I have sought to unsettle assumptions which underpin recent attempts to reduce suicide among men by encouraging 'talk', and to consider some of the effects of such a focus. I have shown that while participant's accounts reproduced existing narratives associating men's inability to talk with ideals of 'traditional' masculinity, these claims need to be approached critically. Men's accounts of their emotional life should be considered in light of

the potential *content* of talk, as well as the *contexts* in which such accounts are produced: both interpersonal or relational contexts and in terms of broader socio-cultural contexts. These shape men's narratives in important ways, and a consideration of each gives cause to question exhortations to men to 'reach out' and 'open up'.

Neglecting the importance of the sometimes-shameful content of men's talk has given rise to social-media campaigns featuring celebrities sharing their troubles, seeking to normalise 'talking' about problems. The problems such celebrities share contrast starkly with the *unsettling* problems participants in this study articulated. Such campaigns effectively erase the role of context and power – sharing is carried out in sanitised ways, by often economically powerful individuals. While such campaigns generate good feelings, I suggest more care needs to be taken with the effects of these in affirming 'talk' as an unproblematic and straightforward response to suicide among men. Emphasising the connection between men, silence, and the problems of 'talking' may serve – perversely – to reaffirm a relationship between masculinity and stoicism, fuelling already circulating narratives about men 'bottling up' problems for long periods of time (and implying women do not do such things). Such campaigns should do far more to attend to the complexity and diversity of 'talking' among men (Seidler et al. 2017) – acknowledging that both talk and silence can be employed in ways which *affirm* masculine status, maintaining gender inequalities and potentially further damaging men, women, and their relationships. Public mental health campaigns would do well to trouble rather than reinforce simplistic narratives about differences between men and women in relation to 'talk'.

Access to mental health support in the UK (and elsewhere) is notoriously challenging. Men in this study described thwarted attempts to 'seek help' from statutory services, finding some solace with community-based services they attended. Relationships with individual workers and peers were described as important, with 'talk' a potential by-product of these. However,

talk was not essential and for some neither talk nor relationships were sufficient in ameliorating distress. Indeed, the community-based service men accessed was praised for the role workers took in supporting men with all aspects of their lives – including accessing benefits and housing. Rather than a focus on 'talk' as a response to suicide among men, suicide prevention initiatives might instead seek to engage more broadly with economic and housing security, access to non-stigmatising welfare/disability support, robust programmes promoting gender equality, easy access to well-resourced community-based services in relation to mental health and substance use. Each of these is of course much more complicated and politically sensitive than encouraging men to 'talk more' about their problems, but without addressing these concerns I would suggest that focusing on 'talk' will be ineffective at best.

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