
WHY IS THE SUICIDE RATE HIGHER IN MEN THAN IN WOMEN?

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INTRODUCTION

Suicide is defined as a deliberate attempt to kill oneself, where the outcome is fatal. This is distinct from both attempted suicide (where there was a definite attempt to take one's own life but it failed) and self-harm (SH), an umbrella term for self-inflicted non-fatal harm regardless of intent (Gulati, Lynall & Saunders, 2014).

Suicide is a complex behaviour with a wide range of underlying causes, including a variety of risk factors which are both environmental/societal and relating to mental illness. For example demographic and individual risk factors include age, gender, medical and psychiatric history, and personality (Chehil & Kutcher, 2012).

This essay will focus on the gender difference in suicide rates – across the world, suicide rates are significantly higher for men compared to women, especially in high income countries, where the average male-to-female ratio is 3.5:1 (World Health Organisation [WHO], 2014).

The reasons behind such a drastic discrepancy are wide and debated, but several factors are commonly accepted as potentially contributing to the higher rate of suicide in men (Brent & Moritz, 1996; Chehil & Kutcher, 2012); compared to women, men choose more lethal methods, are more impulsive, are less likely to seek help for emotional problems, and express depression differently (Rich, Ricketts, Fowler, & Young, 1988). This essay will explore these explanations for male predominance in suicide.

1. METHOD LETHALITY

Despite the suicide rate being higher in men, women typically have higher rates of suicidal ideation and behaviour than men (Cantor, 2000). The difference, therefore, seems to lie in mortality rates, which are lower in women than in men, suggesting that the difference may be in either intent or in the lethality of the method used (Canetto & Sakinofsky, 1998).

Intent is generally not considered to be the reason for this discrepancy: although Rich et al., (1988) used psychological autopsy data to suggest that women are less intent on dying than men, more recent data from Canetto and Sakinofsky (1998) contradicted this, finding that males and females reported equal intent, and Denning, Conwell, King, and Cox (2000)

corroborated this finding. Furthermore, Beautrais et al. (1996) found that the proportion of males and females who made a medically serious attempt was almost equal, but that twice as many women used non-violent methods. This suggests that the difference in suicide mortality between males and females is a result of method choice, rather than intent.

This difference in method choice is strongly supported by statistical evidence – Denning et al. (2000) stated that women use methods such as drug overdose and carbon monoxide poisoning, while men tend to use firearms and hanging. This could explain suicide mortality rate differences, as firearms and hanging leave little chance of rescue and survival compared to drug overdose, carbon monoxide poisoning, or self-cutting (Shenassa, Catlin, & Buka, 2003): men use more lethal methods (Cantor, 2000; Chehil & Kutcher, 2012).

However, it is worth noting that this difference in methods may not apply in the UK and Europe, where it is much more difficult to access firearms than in the US. Despite this, suicide statistics for England and Wales in 2013 showed that the suicide rate is almost four times higher in men than in women (Office for National Statistics [ONS], 2013), and Europe shows similar rates (approximately 3.5:1) to other high-income countries (WHO, 2014). Although at first sight this might suggest that the discrepancy in suicide rates cannot be due to method lethality, it can be reconciled with the method lethality account; the statistics also show that hanging is proportionally more common in men than in women, while women are more likely to use drug overdose as a method in both the UK and Europe generally (ONS, 2013; Värnick et al., 2008). Therefore, the gender difference in method lethality does hold true, despite less availability of firearms in the UK and Europe compared to the US, and could potentially explain male predominance in suicide.

Although it is clear that there is a gender difference in method choice, the reasons behind this are debated including socialisation (i.e. women wanting to avoid disfiguring wounds), access to firearms (men are more likely to own and be familiar with guns), and neurobiological factors such as low serotonin in men (Canetto & Sakinofsky, 1998; Denning et al., 2000). However according to Denning et al. (2000), these theories have not been thoroughly tested by empirical research.

It is also important to note that while the gender difference in suicide rates remains relatively constant across time and countries, suicide methods show huge variation between different time periods and areas (Canetto & Sakinofsky, 1998). This suggests that although method lethality may account for some of the gender difference, it is likely that other factors also contribute to the gender difference in suicide rates.

2. PROPENSITY TO IMPULSIVE BEHAVIOUR

One reason why method choice and also the choice to attempt suicide may differ between men and women is men's propensity to impulsive behaviour. Impulsivity involves acting spontaneously without deliberation (Carver, 2005), and is correlated with (Apter, Plutchik, & van Praag, 1993) and a risk factor for suicide (Maser et al., 2002). It affects suicidal behaviour in two key ways: by influencing the way the suicidal act happens, and how the individual reacts to stressors (Pompili et al., 2009). It is worth noting that Simon et al. (2002) found that suicide is impulsive (i.e. involves less than five minutes' deliberation) in approximately 24% of cases. Impulsivity is, therefore, linked to higher suicide risk.

Impulsivity also affects suicidal behaviour through increasing the risk of developing a psychiatric disorder; according to Pompili et al. (2009), research suggests that impulsive-aggressive personality traits are part of a developmental cascade which increases suicide risk, perhaps predisposing individuals to higher psychopathology and comorbidity. In another study, Turecki (2005) found that comorbidity was especially common in patients with impulsive-aggressive traits, whereas patients without impulsive traits showed comorbidity levels similar to a control group.

Men have generally been found to be more impulsive than women, as they are over-represented in aggressive behaviour, accidents, violence-related injuries, drug use, extreme sports, and criminal behaviour, all of which have been linked to impulsivity (Cross, Copping, & Campbell, 2011). Furthermore, Cross et al.'s (2011) meta-analysis found that men are more impulsive than women, especially in terms of punishment and reward sensitivity (they are more sensitive to rewards and less sensitive to punishment), risk-taking, and sensation seeking. All this evidence strongly suggests that men are more impulsive, which could

explain why the suicide rate is higher in men, given that suicidal behaviour is associated with impulsivity.

However, there is some evidence to contradict a direct causal link between impulsivity and suicidal behaviour: Dear (2000) found that in a sample of prisoners (half of whom had a history of attempted suicide) impulsivity was positively correlated with depression and with measures of suicidal ideation, but that when depression was controlled for, the positive correlation was not significant. This suggests that the association between impulsivity and suicidal ideation is mediated by depression, rather than being a direct consequence of impulsivity.

Furthermore, given that according to Pompili et al. (2009) suicide attempts in impulsive individuals are usually less lethal than suicide attempts in non-impulsive individuals, if the discrepancy in suicide rates were solely attributed to impulsivity in men then, it would logically follow that suicide attempt mortality would be lower in men than in women. However, as discussed in the previous section, there is extensive evidence to suggest that the reverse is true – men have higher suicide attempt mortality rates, as they use more lethal methods. On balance, it can be concluded that although impulsivity may account for some of the difference in the suicide rate between men and women, it cannot fully account for the discrepancy.

3. DEPRESSION: HELP-SEEKING

According to Mościcki (1994), one explanation of the gender discrepancy in suicide rates is the differential rates of depression, whereby women's high rates of suicidal behaviour but low suicide attempt mortality rates can be attributed to their high treatment rates for depression. This is supported by the fact that depression is known to increase suicide risk – Möller-Leimkühler (2003) estimated that major depression underlies more than half of suicides.

This is supported by the finding that rates of diagnosed and treated depression are generally around twice as high in women than in men (Addis, 2008; Brownhill, Wilhelm, Barclay, & Schmied, 2005). Although some researchers have suggested that lower levels of help-seeking in men is a direct result of lower rates of depression (Newmann, 1984; Rickwood

and Braithwaite, 1994), community surveys of the general population indicate only a small gender difference; for example Singleton, Bumpstead, O'Brien, Lee, and Meltzer (2003) found a ratio of 5:6 for men and women.

This suggests that the gender difference lies in help-seeking rather than in rates of depression itself, a premise supported by consistent reports that help-seeking behaviours for mental illness are less common in men than in women (Addis, 2008; Addis & Mahalik, 2003), even when experiencing similar levels of distress (Kessler, Brown, and Broman, 1981). Rickwood and Braithwaite (1994) noted that gender is one of the most consistent predictors of help-seeking behaviour, and research shows that men are more likely to agree that they would not seek professional therapy for depression or even seek help from their friends (Padesky & Hammen, 1981).

This could explain the discrepancy in suicide rates between males and females, as help-seeking results in treatment, which is generally accepted as being more likely to alleviate depression than no treatment at all. Hence men who do not seek help for depression are likely to suffer more severely due to lack of treatment, which could result in an increased risk of suicide. The mechanisms underlying men's reluctance to seek help for depression are debated, with two dominating approaches: sex-differences and gender-role socialisation.

SEX-DIFFERENCES

There are several reasons why this may be the case – the sex-differences approach has proposed that problem recognition or labelling is a factor, a premise supported by studies showing gender differences in recognising symptoms of depression as a problem (Yokopenic, Clark, & Aneshensel, 1983). Furthermore, Kessler et al.'s (1981) meta-analysis on psychiatric help-seeking concluded that men were less likely to seek help compared to women with comparable symptoms, and particularly that men were less likely to recognise and label feelings of distress as being affective problems. This finding has been repeated in a variety of different samples (Addis & Mahalik, 2003), strongly suggesting that there is a sex difference in problem recognition or labelling.

However the processes underlying such a sex difference remain elusive, and sex-difference studies cannot account for inter- and intra-individual variability – not all men will behave

the same way, and situational change can make individual men behave very differently (Addis & Mahalik, 2003). Addis and Mahalik (2003) also note that the sex-difference approach implicitly supports essentialist interpretations of gender, whereby attributes are seen as fixed and defining elements of a category, which is an issue because it can be used as the basis for stereotyping and constraining groups; in this example, men's lower rates of help-seeking could be seen as an expression of self-reliance and used to support their suitability for public economic spheres, while being inferior to women in relational contexts.

GENDER-ROLE SOCIALIZATION

Alternatively, gender differences in help-seeking can be considered in terms of gender-role socialisation, whereby men and women learn gendered attitudes and behaviours from a young age based on cultural values and norms (Addis & Mahalik, 2003). This could link to help-seeking behaviour in that men's gender roles in Western cultures tend to emphasise values such as self-reliance, a lack of vulnerability, and emotional control, which clash with help-seeking behaviours as they involve relying on others, powerlessness, and recognising an emotional problem or uncontrolled expression of emotion (Emslie, Ridge, Ziebland, & Hunt, 2006; Good et al., 1989). Thus masculine gender role socialisation may make it more difficult for men to recognise and seek help for depression (Emslie et al., 2006) – for instance Warren (1983) argues that depression is 'incompatible' with masculinity, as expressing emotion is associated with femininity, and masculinity is linked with competence and self-reliance while depression involves loss of control and vulnerability. Hence, according to Courtenay (2000), men use denial of depression to demonstrate their masculinity and avoid being seen as inferior.

Several studies have examined gender-role conflict and attitudes towards help-seeking (Addis and Mahalik, 2003). For example, Robertson and Fitzgerald (1992) found that certain components of gender-role conflict predicted negative attitudes toward psychological help-seeking, a finding corroborated by Berger, Levant, McMillan, Kelleher and Sellers (2005), Blazina and Watkins (1996), Cournoyer and Mahalik (1995), and Good, Dell, and Mintz (1989). Good and Wood (1995) also found that certain components of gender-role conflict were associated with both an increased likelihood of depressive symptoms and more

negative attitudes toward seeking psychological help, a pattern of relationships that they termed 'double jeopardy'.

However, Rickwood and Braithwaite's (1994) longitudinal study of help-seeking for emotional problems in adolescents found that the gender effect was significant for *general* help-seeking, but not for *professional* help-seeking. They proposed that expressing and confiding in peers is a very different experience for boys and girls, in that for girls it can consolidate friendships by encouraging intimacy, whereas gender norms mean that boys are meant to suppress emotions and so discussing such problems negatively affects peer relationships. They also noted that the lack of emotional expression could account for the higher rate of suicide in males, as they suppress their emotions until they can only cope in 'violently masculine' ways, such as suicide (Rickwood & Braithwaite, 1994).

Qualitative analyses of men's experiences of depression also support the role of gender-role socialisation in preventing help-seeking behaviours – Smith's (1999) case study emphasises the perceived importance among men of suppressing emotion and maintaining control, as well as men not seeking help for 'wimpy' things. Furthermore, O'Brien, Hunt, and Hart (2005) found using focus groups that many men noted the importance of being strong and silent about emotional problems in order to avoid being seen as weak, and when they spoke about depression they often labelled it as 'stress', perhaps as this label carries less stigma.

Emslie et al. (2006), using qualitative secondary analysis on sixteen interviews with men, came to similar conclusions regarding depression being seen as conflicting masculinity (resulting in being seen as weak or receiving homophobic insults) and a difficulty in communicating emotions. They also took this one step further by directly linking gender identities and depression to suicidal behaviour; of the sixteen interviewees, more than half had experienced serious suicidal thoughts or attempted suicide, and their interviews suggested that some had seen suicide as a means of re-establishing control or a way of demonstrating courage, helping them to reconstruct their masculinity. Emslie et al. concluded that some aspects of hegemonic masculinity can be damaging to health and can push men towards considering suicidal behaviour, suggesting that gender-role socialisation contributes to suicidal behaviour both directly and indirectly through help-seeking.

The link between barriers to help-seeking in men and masculine gender-role socialisation is supported by research on barriers to help-seeking. For example, Mansfield, Addis and Courtenay (2005) identified five factors in barriers to men's help-seeking: need for control and self-reliance; minimising problem and resignation; concrete barriers and distrust of caregivers; privacy; and emotional control – all of which correspond to values associated with masculine gender roles. This suggests that men are less likely to seek help for depression than women due to gender-role socialisation, which can therefore be considered to contribute to the gender difference in suicide rates.

On the other hand, it has been suggested that the gender difference in help-seeking may not be the result of sex or gender differences (Galdas, Cheater, & Marshall, 2005). For example Emslie et al. (1999) found that occupational grade explained help-seeking behaviour better than gender did, suggesting that the observed 'gender difference' in help-seeking behaviour may be a product of the behaviours and attitudes associated with certain career and lifestyle choices, rather than some intrinsic quality of gender. Further evidence contradicting gender differences in help-seeking comes from MacIntyre (1993), who found no gender differences in reporting of conditions and no evidence that women were more likely to report mental health conditions. This suggests that the supposed gender difference in help-seeking may in fact be the product of some alternative factor or confounding variable, such as symptom severity, occupational level, or men's expression of depression.

The idea that the underestimation of depression rates in men may be due to a factor other than help-seeking is supported by large-scale epidemiological studies which cold-call stratified samples regardless of prior diagnosis or treatment, which still tend to find a 2:1 female to male ratio of depression (Addis, 2008; e.g. Kessler et al., 1994).

4. DEPRESSION: EXPRESSION

One suggestion which could explain these findings is that although men experience depression in the same way as women, i.e. they score similarly on the BDI, they differ in terms of expression: they show different symptoms (Padesky & Hammen, 1981) and so are not as likely to be diagnosed or treated. It is proposed that men express depression differently either due to sociocultural constraints imposed by traditional concepts of

'masculinity' (Brownhill et al., 2005), biological factors, or coping and response styles (Addis, 2008).

THE MASKED DEPRESSION FRAMEWORK

The masked depression framework posits that depression in men can be hidden by externalising symptoms and problem through behaviours such as substance abuse, suicide, and aggression (Addis, 2008). It proposes that men's responses to depression are shaped by norms regarding masculinity (O'Neil, Good, & Holmes, 1995), including an emphasis on antifemininity, emotional stoicism, and self-reliance (Addis, 2008). This results in a difficulty identifying moods (alexithymia) and a form of 'masked' depression whereby depression is hidden by externalising problems through avoidant, numbing and escape behaviours, which can lead to aggression, violence, substance abuse, and suicide (Addis, 2008; Brownhill et al., 2005). Masked depression in men therefore increases the risk of suicide, which could explain higher rates of suicide in men.

The masked depression framework is supported by indirect evidence, especially the fact that men are over-represented in risk-taking and antisocial behaviours such as suicide attempts, aggression and violence-related deaths, risky sexual encounters, gambling, drink-driving, and substance abuse (including alcohol abuse) (Bennett & Bauman, 2000). These behaviours have been suggested to be a coping mechanism for men experiencing depression who are unable to express their emotions, and are therefore termed 'depressive equivalents' or 'masked depression' (Brownhill et al., 2005). This could also explain the finding that the effect of impulsivity is mediated by depression (Dear, 2000) – impulsivity may just be a symptom of masked depression, suggesting that the ultimate cause of higher suicide rates in men lies in their masked expression of depression.

Additionally, research has suggested that gender socialisation is associated with development of externalised behaviours such as those described by the masked depression framework: aggression, violence, substance abuse, and suicide (Addis, 2008; Brownhill et al., 2005; Cole, Teti, & Zahn-Waxler, 2003; Eisenberg et al., 2001). This could explain higher rates of suicide in men, as it connects masculine ideologies, which are presumed to cause masked depression, with the behaviours it is said to result in. This can be extended to imply

that suicide, as one such behaviour, is a more likely outcome when depression is masked, as it is in men.

Further indirect support comes from evidence suggesting that there is more stigma attached to depression for men – Page and Bennesch (1993) discovered that men scored higher on the Beck Depression Inventory (BDI) when it was presented as a measure of ‘daily hassles’ as opposed to ‘depression’, an effect not found in women. This suggests that there is more stigma attached to reporting depression for men than for women (Addis, 2008), which explains why men might feel the need to hide or ‘mask’ their depression.

The association of these externalised coping behaviours with depression is strengthened by findings that in societies where such behaviours are not an option (due to cultural values or law), the difference between men’s and women’s symptoms decreases (Addis, 2008), for example in Amish people (Egeland & Hostetter, 1983). The externalised coping behaviours seem to be an alternative expression of depression, thereby supporting the masked depression framework.

Furthermore, men’s depression may be masked due to difficulty expressing and identifying their emotions, supported by evidence that being male and demonstrating higher adherence to traditionally masculine norms predicts higher alexithymia scores (Fischer & Good, 1997; Vorst & Bermond, 2001). Additionally, several studies have suggested that men find it more difficult to recognise depressive mood (Brownhill et al., 2005). Unfortunately, no studies have yet directly tested whether depressed men (i.e. the people likely to be masking depression) are less able to recognise depression.

This evidence generally supports the masked depression framework, suggesting that the reporting and measurement of depression in men may not be the same as their experience of depression – they express depression through risk-taking and antisocial behaviours known as ‘masked equivalents’ instead of through symptoms tapped by DSM structured interviews (Addis, 2008). This could explain the gender difference in the suicide rate, as it suggests that men’s depression is hidden and expressed through impulsive and violent behaviours including suicide. It also has the advantage of being able to explain why men are less likely to be diagnosed with depression.

However, Addis (2008) notes that there is no direct evidence to support the existence of masked depression in individual cases – confirmation would be impossible given the DSM's focus on the presentation of symptoms rather than attempting to directly measure the underlying disorders, and such symptoms are, by definition, not present in masked depression.

DISCUSSION

To summarise, the evidence suggests that one of the reasons that the suicide rate is higher in men than in women is that men tend to use more lethal methods, such as hanging, which leave less opportunity for rescue and therefore increases mortality rates for suicide attempts in men. As a countervailing factor to the comparatively high rate of attempted suicide in women, this could partially explain the gender difference in suicide rates. However the reasons *why* men are likely to use more lethal methods still requires further research and explanation, and the fact that methods vary drastically between countries and over time whilst the gender discrepancy remains relatively constant suggests that other factors also contribute to why the suicide rate is higher in men.

This essay has discussed the debate surrounding the role of impulsivity in suicide and concluded that it does play a significant proximal role in cases of impulsive suicide, but that its effect is mediated by depression. Men's help-seeking for and expression of depression are better able to explain the gender difference in suicide rates. Although the majority of the literature suggests that men are less likely to seek professional help for depression, perhaps as a consequence of sex differences in problem recognition or gender-role socialisation, an alternative explanation of lower rates of depression in men is that they express their emotions differently, which ties in with 'masked' expression of depression as a plausible explanation of the gender discrepancy in suicide rates.

In conclusion, the gender difference in the suicide rate can be explained by a combination of several key factors: men choose more lethal methods, may be less likely to seek help for depression, and also express their depression differently to women, meaning they are more likely to behave impulsively (including suicide) and less likely to be diagnosed and effectively treated. However it is clear that even a combination of these factors cannot completely

explain the complex nature of suicide – Chehil and Kutcher (2012) note that understanding suicide is impossible, as its underpinnings are diverse and multifaceted. Although a full understanding may be unattainable, the reasons why the suicide rate is higher in men could be better understood by further research, ideally cross-cultural studies investigating multiple factors simultaneously in order to comprehend how they interact at an individual and population level.

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