Communication and interpretation of emotional distress within the friendships of young Irish men prior to suicide: A qualitative study

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Abstract

The potential for young men in crisis to be supported by their lay networks is an important issue for suicide prevention, due to the under-utilisation of healthcare services by this population. Central to the provision of lay support is the capability of social networks to recognise and respond effectively to young men's psychological distress and suicide risk. The aim of this qualitative study was to explore young men's narratives of peer suicide, in order to identify how they interpreted and responded to behavioural changes and indications of distress from their friend before suicide. In-depth qualitative interviews were conducted with 15 Irish males (aged 19-30 years) who had experienced the death by suicide of a male friend in the preceding five years. The data were analysed using a thematic approach. Through the analysis of the participants' stories and experiences, we identified several features of young male friendships and social interactions that could be addressed in order to strengthen the support available to young men in crisis. These included: the reluctance of young men to discuss emotional or personal issues within male friendships; the tendency to reveal worries and emotion only within the context of alcohol consumption; the tendency of friends to respond in a dismissive or disapproving way to communication of suicidal thoughts; the difficulty of knowing how to interpret a friend's inconsistent or ambiguous behaviour prior to suicide; and beliefs about the sort of person who takes their own life. Community-based suicide prevention initiatives must enhance the potential of young male social networks to support young men in crisis, through specific provisions for developing openness in communication and responsiveness, and improved education about suicide risk.

What is known about this topic:

- Many young men do not engage with healthcare services prior to suicide.

- Lay support systems need to be capable of recognising and responding effectively to distress in young men who are outside the care of services.

- Previous research reported difficulties for lay people in deciphering indications of suicidal crisis.

What this paper adds:

- When indications of distress and suicidal thinking are observed in a young man, effective responses from friends may be hindered by reluctance to raise emotional issues, disapproval of suicide, and factors which make it difficult to decide whether observations represent a real concern.

- Suicide prevention initiatives ought to strengthen communication within male peer support systems and increase awareness of suicide risk.

INTRODUCTION

Suicide is a leading cause of mortality for young men in most high and middle-income countries (Pitman *et al.* 2012)*.* Mental health disorders have been identified in the majority of completed cases of youth suicide examined by psychological autopsy research, but very low rates of contact with mental health services have been reported (Houston *et al.* 2001, Renaud *et al.* 2009). Young men in particular are less likely than other population groups to seek help from primary or specialist healthcare services prior to suicide (Luoma 2002, Foster *et al.* 1997). This is in line with the wider literature base concerning male reluctance to seek help from either lay or professional sources when faced with symptoms of emotional or psychological distress (Biddle *et al.* 2004, Jorm *et al.* 2006). Gender role socialisation typically imposes higher thresholds for males than females in terms of emotional expression of sadness, insecurity and vulnerability, and help-seeking behaviours are frequently perceived to be at odds with the expected characteristics of the traditional male gender role (Moller-Leimkuhler 2003). Qualitative research with young men who engaged in suicidal behaviour found that many attempted to conceal their difficulties and emotions from family and friends, due to fear of transgressing masculinity norms (Cleary 2012).

While much research and policy attention has been paid to the unwillingness of young men in crisis to disclose their distress to others, we must equally examine the capability of the social network to

recognise and respond appropriately to distress. This is particularly important for suicide prevention for young males who are not receiving care from primary or secondary health services, as any behavioural changes or symptoms of distress they exhibit before suicide will only be observed by their family or friends. Males may also convey their distress in ways which are difficult to interpret, due to gender role constraints surrounding emotional expression (White 2006). This is likely to pose significant challenges for the support network of a young man in crisis. The purpose of the current study was to explore young male narratives of peer suicide, in order to identify how young men interpreted and responded to behavioural changes and indications of distress from their friend in the period leading up to his death. An understanding of the social context of young male suicide will inform the development of community-based suicide prevention efforts to strengthen the response of peers, friends and colleagues to young men in crisis (Owens *et al.* 2009). Effective support from social networks may increase the likelihood of early medical attention (Kelly *et al.* 2007).

The use of qualitative methods to study lay understandings of health and illness is well established (Helman 2007), but within the field of suicide research the importance of understanding lay perspectives has only recently been recognised (Gavin & Rogers 2006). The current study builds on previous qualitative research that explored accounts of the suicidal process provided by bereaved family members and friends *(Owens et al.* 2005, Owens *et al.* 2008, Owens *et al.* 2011). These studies have highlighted the difficulties lay people experience in evaluating whether perceived changes in mood and behaviour in a family member or friend are serious and worthy of medical attention, and the challenges involved in actually intervening. The current study is the first to specifically focus on the interaction within young male friendship networks prior to suicide, in order to understand the specific ways in which these support networks could be strengthened. The research was conducted in the Republic of Ireland. At the time of the study, Ireland had the fourth highest youth suicide rate (15-24 year olds) in the EU countries, with a rate of 30.7 per 100,000 for young males aged 20-24 years (National Office for Suicide Prevention 2010).

METHOD

Design

We conducted a qualitative study of completed peer suicide, through in-depth individual interviews with young adult Irish males, aged 18-30, who had experienced the death by suicide of a male friend in the preceding five years. The study was designed to elicit young men's narratives of the circumstances surrounding the death of their friend, particularly focusing on the nature of social interaction and communication with the deceased in the period leading up to the suicide. Ethical approval for the study was provided by the Ethics and Medical Research Committee at St. Vincent's University Hospital, Dublin, Ireland. Interviews were conducted between 2009 and 2010.

Recruitment and sampling

Participants were recruited through regional and national newspaper articles, regional radio programmes, community gatekeepers, and an extensive poster advertisement campaign at employment training centres, university campuses, sports clubs, and public areas within numerous towns and villages. Four participants were also recruited through snowball sampling via participants of a wider psychological autopsy research study led by KM (Malone 2013). All participants provided written informed consent prior to their research interview.

Interviews

The study aimed to elicit uninterrupted accounts of participants' experiences to facilitate greater interpretation of meaning (Kvale 1996). At the beginning of each interview, participants were asked an open-ended question which encouraged them to tell their own story of their friend and the circumstances surrounding his death, e.g. *"We're here today to talk about Eric. What would you like to tell me, in your own time, about Eric and about what was going on in his life around the time that he died?"* This approach also allowed participants to define the tone and pace of the interview from the outset, so that they might feel more comfortable and secure in sharing their understanding of

events. Following the initial narrative, probing questions were asked for further clarification or elaboration of the issues raised by the participant. A flexible topic guide was then used to guide the conversation towards the main issues relating to the research question, if these had not already been discussed. Participants were asked with whom their friend used to speak if he was having problems, whether he had ever spoken to anyone about suicide before, whether he was in contact with healthcare services, and how he seemed the last time they saw him. Participants were encouraged to speak freely about each of these issues at their own pace.

All participants were offered the opportunity to be interviewed at home. Seven participants opted to be interviewed in meeting rooms in local universities or hospitals. All interviews were conducted by LS and were typically 2-3 hours in length. Interviews were audio-recorded with consent and participants consented to the publication of their interview data using pseudonyms.

Analysis

Interview recordings were transcribed verbatim. Pseudonyms were assigned to each interviewee, their deceased friend, and any other named person in the interview content. A thematic analysis was conducted, which aimed to identify and interpret patterns, or themes, across the dataset that represented the beliefs and experiences of the participants in relation to the research question (Braun & Clarke 2006). Two of the researchers (LS and CO) independently examined the content of the first three interview transcripts and agreed on an initial coding framework that seemed to capture the key ideas, themes and issues within the interview data. This framework was used to organise the data into analytic categories and it was further developed and refined as it was applied to later transcripts, with the assistance of the NVivo8 software package. Methods of constant comparison were used to examine in depth the range and nature of the themes within the data and the similarities and differences between participants in relation to each theme. Detailed descriptive accounts were produced for each major theme, alongside the relevant extracts from participants' transcripts. LS and KM held regular meetings to discuss and refine the content of the emerging themes. Ongoing analysis

and interpretation were also informed by consulting relevant literature. Analysis continued until no new themes were emerging from additional transcripts.

FINDINGS

<u>Overview</u>

Fifteen young adult Irish males, aged 19-30 years, participated in the research interviews. Table 1 shows characteristics of the sample. In the majority of cases (n=12), the participant's friend had died from hanging. In the remaining three cases death was caused by overdose, jumping and drowning.

The participants provided poignant descriptions of the emotional upheaval in the aftermath of their friend's death. Many described how they had had the same male friendships since childhood and they conveyed the importance of these friendships for their lives. While psychological autopsy research has consistently identified mental illness as a major factor in youth suicide, using post-mortem diagnostic methods (Isometsa 2001), the participants in our study did not recount stories of mental illness when speaking about their interaction with their friend before his death and their perception of his situation at that time. Through the analysis of the participants' stories and experiences, we identified several features of young male friendships and social interactions that could be addressed in order to strengthen the support available to young men in crisis. These included: the reluctance of young men to discuss emotional or personal issues within male friendships; the tendency to reveal worries and emotion only within the context of alcohol consumption; the tendency of friends to respond in a dismissive or disapproving way to communication of suicidal thoughts; the difficulty of knowing how to interpret a friend's inconsistent or ambiguous behaviour prior to suicide; and beliefs about the sort of person who takes their own life.

Reluctance to discuss emotional issues within male friendships

Many of the participants spoke about how young men typically do not talk about emotional or personal issues when they interact with their male friends: "*Lads are lads, you don't really talk to each other like that.*" Participants indicated that intimate relationships with females, such as a girlfriend or mother, provide the main opportunity for sharing emotional and personal concerns. When the participants referred to spending time with their male friends, this typically involved getting together for shared activities, such as watching television, playing football or drinking in the pub, with an emphasis on light-hearted, fun interaction and banter, where matters of real personal concern were not raised or discussed. Several participants claimed that their friend who died had hidden his emotions and concerns from his male friends, and that no-one could have known how he was feeling around the time of his death.

Some participants indicated a sense of unease surrounding talking about personal problems within male friendships, to the extent that even if one was aware that a friend was troubled, it would be difficult to question him about his well-being or personal difficulties, or invite him to confide. For example, one participant spoke about how his friend had experienced a number of significant bereavements within his family, but these losses were not talked about with his friends. The participant acknowledged that there was a collective avoidance of such personal issues within the group of friends:

> "*I suppose it sounds strange now...strange that he didn't talk about it [the losses within his family]. But I suppose we would've skirted around the issue, I suppose fellas don't directly talk about stuff like that, you know that kind of way?*" (Niall)

Participants conveyed a sense of discomfort, uncertainty and lack of confidence about how to respond when unusual or problematic behaviour was observed in a friend. In some cases, participants had noticed changes in the deceased's mood or behaviour and had spoken with other friends about it, but the challenge appeared to be in actually raising the issue with the friend in question (the deceased).

Two participants had confronted their friend before his death about specific risky behaviours that they disapproved of, namely driving under the influence of alcohol and selling drugs, but more general low mood and departures from normal conduct seemed to be more difficult to tackle:

> *"I sort of knew he wasn't himself. That night I said, 'Jesus, it's not like Eric to walk off'. And we all said that, 'It's not like him'. But after that that was it, there was nothing like, 'Are you OK?' No-one ever said it to him, and then we got the word that he done it."* (Glen)

> *"We knew he was just getting out of control... Yeah we would've talked about it as a group, about what to do with him, but sure we didn't know. How do you get a fella to stop drinking? We didn't want to be patronising him either, you know that kind of way?"* (Niall)

Some participants regretted that the young men in their friendship group did not feel comfortable discussing worries and concerns with one another, as they believed it might have made a difference if the deceased had been able to share with them how he was feeling. At the same time, they conveyed a sense of inevitability about the fact that men do not like to talk about their feelings and a lack of belief that the nature of male interaction could change:

> "*Fellas don't talk about things like that I suppose... It'd be better if we did. That would've helped. But they don't, so … I don't know if that's gonna change very quickly.*" (Aidan)

It is important to note that not all of the young men interviewed had the same experiences. Some claimed that their friend was able to confide in them about his personal problems and about how he was feeling before he died, particularly in the context of a one-to-one interaction, rather than as part of a group.

Revealing worries and emotions in the context of alcohol consumption

Participants referred to how young men are typically more comfortable speaking about serious issues when drinking with friends than in other kinds of interaction:

> *"Lads will only talk when there's beer on board, you know, when the guard is down."* (Éamonn)

Several participants referred to instances *"when we had a few pints on us,"* when their deceased friend had revealed specific personal issues that he had not previously disclosed, such as a girlfriend's abortion, or previous contact with mental health services. Two participants told how their friend had communicated his suicidal thinking to them or others when they were drinking together. Some participants also referred to occasions in the months before their friend's suicide when he became aggressive or visibly emotional in front of them whilst drinking.

Participants spoke about how emotions or disclosures that were divulged while drinking were typically concealed again the following day when sober, by putting *"the hard man act"* back up, or were dismissed by those who had heard or observed them. There was an assumption that the friend had not meant what he said, or that he might not remember it, and that it was therefore best to put it aside:

> *"Thomas was fairly drunk that night... he was kind of rambling, but he was saying something like, 'I'm just going to finish it, I'm going to end it all,' and we were kind of like, 'What are you on about? Shut up.' ... We just kind of put it down to drunk talk."* (Aidan)

Responding to a friend's disclosure of suicidal ideation

Several participants spoke about how they responded to their friend's disclosure or indication that he had been experiencing suicidal thoughts. Some had dismissed the idea and told their friend that suicide was *"a stupid thing to do."* One of the participants had discussed the potential consequences of the suicide with his friend, emphasising the distress and detrimental outcomes for those left behind. In this way, he had shown his disapproval at the idea of suicide:

> *"I was like, 'What if I start drinking or taking drugs or something and then my life is ruined because of what you did?'"* (Ronan)

Similarly, another participant described an occasion where a friend had called him for help when thinking of attempting suicide and he had responded by trying to make his friend feel guilty over the distress his death would cause for others. They had both already experienced the suicide of a friend, and the participant admitted that he had become very angry at the thought that it might happen again:

> *"...He was trying to cut his wrists with his key, he had them cut a little bit. And I just went, 'Ya f***in' eejit. What the f***?' And I was just sitting there talking to him because they weren't cut that bad that you'd have to rush him to a hospital. Just saying like, 'What's the point in doing that? We already lost one mate to it and now you want to do it?' I just went mad at him and he was saying, 'I know, I know, I'm sorry.'"* (Keith)

Participants indicated that they had not explored with their friend the reasoning behind his suicidal thinking, either at the time of disclosure or later, nor had they sought advice on managing the situation from either lay or professional sources of support. Some participants had been reassured by their friend that he would not go through with suicide. One described how he had initially thought of seeking help for his friend, but had changed his mind in light of his friend's reassurance that the suicidal thinking had passed:

"He brought me out into the shed and he was like, 'Oh see the rafters there? I actually had a noose hanging out of that, but because we talked it all out I'm after taking it down'... then you're kind of thinking, oh well it's OK, it's down now...." (Ronan)

Difficulty in interpreting the friend's behaviour at the time

Several participants attributed significance to events around the time of their friend's death which they believed in hindsight may have indicated that he was feeling distressed or reflective at that time. This included risky behaviour, becoming emotional when drinking, or surprising acts, such as opening a bottle of champagne with friends the night before he died. At the time, however, participants did not question what they observed, as they claimed that these actions occurred in conjunction with other normal everyday behaviours, such as making jokes or making plans for the upcoming weekend. Some participants claimed that in their last interaction with their friend his behaviour had appeared normal and there was nothing that would cause them concern, even if previously he had appeared worried or showed unusual behaviour. Several participants indicated that it was difficult to interpret their friend's behaviour around the time before his death as it was not consistent:

"He was very upset about it [relationship break-up]. I knew that... But I still remember having jokes with him that weekend on the bus trip home, we were laughing a bit." (Barry)

For some participants, their friend's mood or behaviour around the time of his death was perceived to be a normal response to circumstances, for example, being very upset following a relationship break-up. Others had become accustomed to emotional highs and lows in their friends, which perhaps made it difficult to recognise when the situation was a cause for concern:

"Sometimes he'd get a bit of drink in him and he'd break down and other times he'd be great fun and he'd be up for a laugh and go streaking or whatever would be going on." (Ronan)

One of the participants claimed that his friend had a *"very morbid sense of humour"* and made many references to his own death in a humorous fashion. These references were interpreted at the time as an eccentricity of character, which did not cause any alarm:

> *"About three or four months, maybe a year, before this happened, he'd talk about things like his funeral. Funny guy, he'd say that at his funeral he wanted a karaoke wake... joking about giving his stuff away to people."* (Shane)

Beliefs about who is at risk of suicide

Many of the young men interviewed believed that their friend was an unlikely person to take his own life, and some emphasised that he was the *"last person"* they would have expected to die in such a way. Some participants perceived that their friend *"had everything going for him"*, and had advantages over others in terms of material circumstance, sporting ability, or popularity. Participants indicated that self-isolation is an expected behaviour in someone at risk of suicide, and they talked about how their friend, in contrast, had lots of friends, had no difficulties in terms of getting along with others, and was *"never on his own."* Participants conveyed the belief that they would not expect suicide to occur in a young man with social confidence and social support:

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

Some participants also believed that suicide was associated with very low mood, which they had not witnessed in their friend:

> *"He'd never just sit in his house and be down."* (Glen)

Several of the participants referred to the notion of 'signs' of an impending suicide and they believed that their friend had not displayed emotions or behaviours which would constitute signs. Participants' use of the term 'signs' was quite vague and many did not fully explain what they meant by the term, but some claimed that previous suicide attempts or a mental illness would be signs that an individual may be at risk of suicide. Some participants contrasted the death of their friend with other cases of suicide by young men from their communities who were perceived to fit the profile of a suicide victim. They suggested that the dominant discourses in their communities regarding suicide risk in young men were concerned with social difficulties, self-isolation, and adverse life circumstances, such as drug abuse or debt.

Beliefs and assumptions about the sort of people who take their own lives and the behaviours they display may influence one's view of whether or not someone is at risk of suicide. For example, one participant in the current study spoke about how his friend had told him that he was having suicidal thoughts, but the participant had believed that his friend was not otherwise showing any indications of significant distress:

> *"I suppose me and Donagh [another friend] were kind of the only people that knew [about their friend's suicidal thoughts] and we didn't do anything, but you know the way you just…in work the next day and it was gone out of my head. But nobody else really knew and it's not like he... things seemed to be stable enough for him, there weren't any tell-tale signs at the time."* (Ronan)

Similar to the previous theme, the perceived inconsistency between the friend's indication of suicidal thoughts and his life circumstances perhaps made it difficult for the participant to recognise when the situation was a cause for concern.

4.   DISCUSSION

The current study has identified patterns of interaction within young male friendships and beliefs about suicide that may limit the potential of these networks to recognise and respond to suicidal distress. Our findings suggest that within young male friendships, emotions and personal issues are typically not discussed, nor is their disclosure encouraged, resulting in limited scope to share concerns and receive emotional support within peer networks. Previous studies that have looked at interaction within male friendships have similarly found infrequent discussion of personal issues (Aries & Johnson 1983, Giles Williams 1985). Our findings have also called attention to the uncertainty and lack of confidence that young men experience regarding whether to intervene when their friends show changes in their behaviour or their well-being, and how to go about providing the necessary support. Drinking alcohol with friends was identified as the social context where young men's concerns and emotions were more likely to be revealed to their friends and where disclosures of suicidal thinking may occur. Alcohol is frequently used as a coping strategy and method of self-medication by young males experiencing distress (Ritchie 1999, Cleary 2012) and in light of the disinhibitory effects of alcohol consumption it is perhaps unsurprising that indications of distress are revealed in this context. At the same time, our findings indicate that distress or suicidal thinking communicated to friends within the alcohol context may be discounted as "drunk-talk", making it less likely that friends will take these communications seriously and intervene.

Our findings suggest that when faced with peer disclosure of suicidal ideation, young men may respond by being dismissive, angry, or disapproving about their friend's disclosure, rather than discussing the reasons behind suicidal thinking. Males have previously been found to be less likely than females to engage in active listening with their friends, which involves acknowledging the thoughts and feelings of the other individual and encouraging reflection on what they are saying (Leaper *et al.* 1995). Our data also supports the work of Owen *et al.* (2012) in relation to 'suicide communication events', which showed how communication about suicidal thinking from the person

in distress can be closed down by the person who receives the information, due to fear, anger, or uncertainty about what to do. Of concern is that if a young man receives a negative response to his disclosure of suicidal thinking from his peers, he may be reluctant to confide in them again. The participants in our study referred to both direct and indirect communications about suicidal ideation. Suicide can be an emotionally threatening subject for people to discuss and 'face-saving strategies' may be used by those in distress to communicate their suicidal thinking in indirect or ambiguous ways, e.g. through humour, or when under the influence of alcohol (Owen *et al.* 2012). This leads to difficulty for others in interpreting the intention of the communication.

Our study confirms previous research findings regarding the difficulties lay people experience in weighing up signs of distress and deciding whether or not any action is required. Our findings support the idea of 'signs and countersigns' proposed by Owens *et al.* (2011), whereby an individual contemplating suicide may send inconsistent signals to those around them, making it difficult for their friends and family to gauge whether they should be concerned and whether they need to intervene. Judging the severity of another's distress is particularly difficult when aberrant behaviours occur alongside normal ones, since the latter tend to override or cancel out the former (Owens *et al.* 2005, Owens *et al.* 2011). Those who are aware of suicidal thinking in a friend may be too ready to accept assurances that suicidal thinking will not be acted upon. Lay judgements may also depend on whether the distress is viewed as an expected response to circumstances or life events, such as the break-up of a relationship.

The notion of 'candidacy' has been proposed in reference to lay theories about the type of person who is expected to experience a specific health event (Davidson *et al.* 1991). Our findings suggest that young men may hold specific representations of suicide candidacy, involving social isolation, adverse life circumstance, diagnosed mental illness, and previous suicide attempts. While these beliefs may be consistent with specific risk factors identified within the scientific suicide literature, they are not aligned with many of the stories of the participants in the current study, where the deceased was

generally perceived to be a sociable person with a good life and no indication of mental illness. The importance of candidacy for suicide prevention is that lay theories, or popular beliefs about suicide risk, can impair detection of suicidal behaviour in others and obscure messages that suicidal individuals are trying to convey about their risk (Hjelmeland & Knizek *2004,* Walker *et al.* 2006).

Strengths and limitations

To our knowledge, this is the first study to focus on peer suicide from the young male perspective. Using systematic research methods to gather the stories and experiences of young men who lost a friend to suicide provided rich data and unique insights into the nature of their social and interpersonal interaction with the deceased, and the ways in which they interpreted and responded to events preceding the suicide. Previous research studies have drawn attention to the challenges involved in recruiting young adult males to participate in research concerning emotional issues *(e.g.* Ritchie 1999*,* Begley *et al.* 2004) and it is strength of the current study that we recruited a hard-to-reach sample for in-depth qualitative research. At the same time, due to the nature of recruitment for a study of this kind, where those bereaved by suicide volunteer to be interviewed about their experiences, it is inevitable that the study sample will contain a self-selecting bias. Participants who volunteer for psychological autopsy research have been found to live in relatively stable social circumstances (Appleby *et al.* 1999). The majority of young men who participated in the current study were university students or professionals; our sample was thus not representative of the overall young male population in Ireland, and did not correspond with the socio-demographic risk factors associated with male suicide risk, including low educational attainment and socio-economic disadvantage (Lorant *et al.* 2005). We do not claim that the findings of the current study are generalisable to all young males who have experienced peer suicide. Rather, the research sought to identify and understand shared experiences and observations within the young male participants, and to use the wider literature to

support the plausibility of the findings (Donovan & Sanders 2005).

The data for the current study were based on retrospective accounts of suicide. Participants' recounting of events was likely to have been influenced by their emotions, their memory of the events that occurred, and their ascertainment of their own role in these events. In telling the story of the pathway to suicide, the bereaved can construct accounts which meet their own need to find meaning in death and reduce their burden of guilt and responsibility (Owens *et al.* 2008). This is the main methodological limitation for all suicide research studies which rely on information provided by bereaved family and friends, including the quantitative psychological autopsy approach (Hawton *et al.* 1998).

Conclusion

To date, research and policy concerning young male suicide risk has tended to focus on the male tendency to conceal mental distress as the impediment to intervention. However, suicide prevention campaigns that urge young men to disclose their worries and concerns to others are unlikely to be effective if such disclosure is neither encouraged nor effectively managed within their social networks. Suicide prevention initiatives for young men outside the care of services must include specific provisions for fostering confidence within young male social networks about raising sensitive emotional subjects, developing openness in communication, and encouraging appropriate responses to disclosure of suicidal ideation, thus providing those who are feeling suicidal with more opportunities for support.

Suicide prevention measures that inform people to be aware of signs of distress or unusual behaviour in others as a risk factor for suicide must take into account that there are numerous ways in which such behaviour can be explained away, or normalised, when it occurs. Community-based suicide

prevention campaigns must emphasise to young men that emotional behaviour or disclosure of suicidal ideation by a friend who has been drinking alcohol may represent real thoughts and feelings and should not be underestimated or dismissed. Young men need to be encouraged (perhaps through advertisements within the alcohol context, e.g. posters on bathroom doors of bars) to look out for and follow up on distress that is observed within this context. Furthermore, while young men should be educated regarding known risk factors for suicide, it should perhaps also be stressed that these risk factors may occur in varying levels and that suicidal behaviour is not limited to those in identified high-risk groups.

Table 1. Characteristics of interview participants

Interview	Pseudonym	Age of interviewee	Occupation at interview	Length of time since death at interview
01	Mark	20	University student	1.5yrs
02	Barry	22	University student	2.5 yrs
03	Ronan	19	University student	2 yrs
04	Dave	20	University student	2 yrs
05	Darragh	23	University student	4 yrs
06	Keith	21	Manual skills employment	4 yrs
07	Glen	22	Manual skills employment	4 yrs
08	Niall	30	Professional	1.5 yrs
09	Aidan	28	Professional	5 yrs
10	Ciarán	19	University student	9 months
11	Gareth	25	Professional	3.5 yrs
12	Alan	26	Professional	4.5 yrs
13	Philip	27	Unemployed graduate	1.5 yrs
14	Eamonn	28	Professional	5 yrs

15	Shane	30	University student	3.5yrs

REFERENCES

Appleby, L., Cooper, J., Amos, T. & Faragher, B. (1999) Psychological autopsy study of suicides by young people aged under 35, *British Journal of Psychiatry*, 175, pp.168-174.

Aries, E.J. & Johnson, F.L. (1983) Close friendship in adulthood: Conversational content between same-sex friends, *Sex Roles, 9 (12)*, pp.1183-1196.

Beautrais, A.L. (2000) Risk factors for suicide and attempted suicide among young people, *Australian and New Zealand Journal of Psychiatry*, 34, pp.420-436.

Begley, M., Chambers, D., Corcoran, P. & Gallagher, J. (2004*) The Male Perspective: Young Men's Outlook on Life.* Dublin: Suicide Prevention Office.

Biddle, L., Gunnell, D., Sharp, D. & Donovan, J. (2004) Factors influencing help seeking in mentally distressed young adults: a cross-sectional survey, *British Journal of General Practice*, 54, pp.248-253.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3, pp.77-101.

Davison, C., Davey Smith, G. & Frankel, S. (1991) Lay epidemiology and the prevention paradox: the implications of coronary candidacy for health education, *Sociology of Health & Illness*, 13(1), pp.1-19.

Donovan, J. & Sanders, C. (2005) Key issues in the analysis of qualitative data in health services. In Bowling, A. and Ebrahim, S. (eds.) *Handbook of Health Research Methods- Investigation, Measurement and Analysis*. UK: Open University Press.

Eckersley, R. & Dear, K. (2002) Cultural correlates of youth suicide, *Social Science & Medicine*, 55, pp.1891-1904.

Foster, T., Gillespie, K. & McClelland, R. (1997) Mental disorders and suicide in Northern Ireland, *British Journal of Psychiatry*, 170, pp.447-452.

Gavin, M. & Rogers, A. (2006) Narratives of suicide in psychological autopsy: Bringing lay knowledge back in, *Journal of Mental Health*, 15(2), pp.135-144.

Giles Williams, D. (1985) Gender, masculinity-femininity, and emotional intimacy in same-sex friendship, *Sex Roles, 12(5/6), pp.*87-600.

Hawton, K., Appleby, L., Platt, S., Foster, T., Cooper, J., Malmberg, A. & Simkin, S. (1998) The psychological autopsy approach to studying suicide: a review of methodological issues, *Journal of Affective Disorders*, 50, pp.269-276.

Helman, C.G. (2007) *Culture, Health and Illness, Fifth Edition.* New York: Oxford University Press.

Hjelmeland, H. & Knizek, B.L. (2004) The general public's views on suicide and suicide prevention, and their perception of participating in a study on attitudes towards suicide, *Archives of Suicide Research*, 8, pp.345-359.

Houston, K., Hawton, K. & Shepperd, R. (2001) Suicide in young people aged 15–24: a psychological autopsy study, *Journal of Affective Disorders*, 63, pp.159-170.

Jorm, A.F., Kelly, C.M., Wright, A., Parslow, R.A., Harris, M.G. & McGorry, P.D. (2006) Belief in dealing with depression alone: Results from community surveys of adolescents and adults, *Journal of Affective Disorders,* 96, pp.59-65.

Kelly, C.M., Jorm, A.F. & Wright, A. (2007) Improving mental health literacy as a strategy to facilitate early intervention for mental disorders, *The Medical Journal of Australia, 187 (7),* pp.26.

Kvale (1996) *Interviews: An Introduction to Qualitative Research Interviewing*. London: SAGE Publications Ltd.

Leaper, C., Carson, M., Baker, C., Holliday, H. & Myers, S. (1995) Self-disclosure and listener verbal support in same-gender and cross-gender friends conversations, *Sex Roles*, 33(5/6), pp.387-404.

Lorant, V., Kunst, A.E., Huisman, M., Costa, G. & Mackenbach, J. (2005) Socio-economic inequalities in suicide: a European comparative study, *British Journal of Psychiatry, 187,* pp.49-54.

Luoma, J.B., Martin, C.E. & Pearson, J.L. (2002) Contact with mental health and primary care providers before suicide: A review of the evidence, *American Journal of Psychiatry,* 159: 909-916.

Malone, K.M. (2013) *Suicide in Ireland 2003-2008.* http://www.3ts.ie/wp-content/uploads/2013/05/Suicide-in-Ireland-Survey-2003-2008-Report.pdf

Moller-Leimkuhler, A.M. (2003) The gender gap in suicide and premature death or: Why are men so vulnerable? *European Archives of Psychiatry and Clinical Neuroscience, 253*, pp.1-8.

National Office for Suicide Prevention, Ireland (2011) *Annual Report 2010.* Ireland: Health Service Executive.

Owens, C., Lambert, H., Donovan, J. & Lloyd, K. (2005) A qualitative study of help seeking and primary care consultation prior to suicide, *British Journal of General Practice*, 55, pp.503-509.

Owens, C., Lambert, H., Lloyd, K. & Donovan, J. (2008) Tales of biographical disintegration: How parents make sense of their son's suicides, *Sociology of Health & Illness*, 30(2), pp.237-254.

Owens, C., Owen, G., Lambert, H., Donovan, J., Belam, J. & Rapport, F. (2009) Public involvement in suicide prevention: understanding and strengthening lay responses to distress, BMC Public Health, 23(9), pp.308

Owens, C., Owen, G. Belam, J., Lloyd, K., Rapport, F., Donovan, J. & Lambert, H. (2011) Recognising and responding to suicidal crisis within family and social networks: qualitative study, *British Medical Journal,* 343:d5801

Owen, G., Belam, J., Lambert, H., Donovan, J., Rapport, F. & Owens, C. (2012) Suicide communication events: Lay interpretation of the communication of suicidal ideation and intent, *Social Science and Medicine, 75*: 419-428.

Pitman, A., Krysinka, K., Osborn, D. & King, M. (2012) Suicide in young men, *Lancet,* 379: 2382-2392.

Renaud, J., Berlim, M.T., Seguin, M., McGirr, A., Tousignant, M. & Turecki, G. (2009) Recent and lifetime utilization of healthcare services by children and adolescent suicide victims: A case-control study, *Journal of Affective Disorders*, 117, pp.168-173.

Ritchie, D. (1999) Young men's perceptions of emotional health: research to practice, *Health Education*, 2, pp.70-75.

Walker, R.L., Lester, D. & Joe, S. (2006) Lay theories of suicide: An examination of culturally relevant suicide beliefs and attributions among African Americans and European Americans, *Journal of Black Psychology*, 32(3), pp.320-334.

White, A. (2006) Men and mental well-being- Encouraging gender sensitivity. *The Mental Health Review,* 11(4), pp.3-6.