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Young People, Gender and Suicide

A Review of Research on the Social Context

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Abstract

- *Summary*: The paper reviews some recent research on the social context of suicide in young people, with particular reference to evidence about the gendered character of suicidal behaviour. Some implications for social work and social policy are discussed.
- *Findings*: Key messages from the research reviewed are presented in relation to some specific social domains. These are employment, social cohesion and social comparison, mental illness, family and relationships, sexual orientation and help-seeking.
- *Applications*: This review is especially of use to those in the social work field who are not familiar with the large body of research on the social context of youth suicide in the medical and psychological literature. There is some discussion in the article of the implications of this research for suicide prevention, both in terms of policy and in terms of the practices of individual social workers.

Keywords gender review suicide youth

Introduction

The gendered nature of suicidal behaviour is well documented, with men more likely than women to kill themselves and women more likely to self-harm. Men's suicide rates are higher than women's across Europe (Hearn et al., 2002) and the Western world in general (Cantor, 2000). In England and Wales, 78 per cent of suicides reported to coroners in 2001 were by men (Home Office, 2002). There has been particular concern about suicide in young men, in the light of this group experiencing the biggest rise in suicide rate through the latter half of the 20th century. In the Department of Health's *National Suicide Prevention*

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Strategy, we are told that suicide has become the most common cause of death among men under 35 years of age in England (DH, 2002).

Announcements of new statistics on the rising suicide rate in young men have attracted a great deal of media attention that is to be expected in the context of a general preoccupation with the so-called 'crisis in masculinity'. The most recent figures for England do in fact show suicide rates in young men to be decreasing since 1998, although the gender gap in suicide rates is still largest in the 20–29 age group (NIMHE, 2005). Although gender is only one feature of social differentiation in suicidal behaviour, it is demonstrably important. Yet gender is often overlooked in mainstream suicide research. The recent state-of-the-art text, *The International Handbook of Suicide and Attempted Suicide* (Hawton and van Heeringen, 2000), for example, does not have a specific chapter on gender, although several chapters do make reference to gendered trends in suicidal behaviour. This article will highlight questions of sex and gender in reviewing some of the evidence about the social context of suicide in young people and its implications for gearing social work and social policy towards suicide prevention.

In the light of the increased rate of suicide in young men, research on the social construction of masculinity is highly relevant to this article. In addition to well-established research programmes on women's health, in recent years there has been a burgeoning interest in men's health in general. As Connell (2000) observes, there is often a mistaken tendency in literature on this topic to overemphasize the poor health of men and to underestimate both commonality across sexes and the significant variation between men in terms of social class and ethnicity. Connell notes, however, that 'some masculinizing practices damage bodies' (p. 184). These include men's more hazardous occupations, greater risk-taking, greater ignorance about their health, and also reluctance to seek medical help (Hearn et al., 2002). This article will not, however, attempt to summarize the emerging insights from the more general men's health literature, but will focus on research evidence in relation to suicidal behaviour specifically.

Stack (2000: 146) provides a useful overview of observed differences between men and women which might explain men's higher suicide rates (see Table 1). His summary mentions gendered trends in terms of the impact of traditional roles, gendered behaviour and attitudes, social networks and life skills.

This is a useful starting point for our review. Some of the factors in Stack's summary will be discussed in what follows, and some will not. We have chosen to focus rather more specifically on several domains of experience that are especially important for social work and social policy, namely employment, social cohesion and social comparison, mental illness, family life, sexual orientation, and help-seeking behaviour. For each of these themes we will draw out potential implications for a range of policy areas. Our review moves in and out of analysis which is sex- and gender-specific and that which is more generally about young people. This is in keeping with the variety of approaches found in the suicide research literature, some of which is explicit about sex/gender issues and some of which is not.

Table 1 **Summary of sociological research on gendered behaviour with implications for suicide rates (from Stack, 2000)**

- More men than women abuse alcohol.
- The religiosity level of women is significantly higher than that of men.
- Women have stronger negative attitudes towards the acceptability of completed suicide but more positive attitudes towards suicide attempts.
- Women have more flexible coping skills than men. This has been explained in terms of women having a greater number of role changes than men in the life course.
- Women are apt to recognize and less apt to deny the warning signs of suicide such as depression than are men.
- Women are more likely to seek professional help.
- Women have more extensive social support systems to draw on when in crises than men.
- Some aspects of the dominant model of masculinity increase risk of lethal suicidality, including competitiveness, impulsiveness–decisiveness, and being 'strong'.
- Historically, women have had less access to lethal technology such as firearms.
- Failure in the primary adult male role (economic success) is more visible and obvious than failure in the primary female role (success in relationships). Men are more apt to feel like failures in their primary role and, hence, more likely to kill themselves.

Clearly it is important to analyse differences between men and women as sex groups, since there are clear differences in terms of suicidal behaviour. It is also important to consider more subtle and complex differences according to gender identities: that is, the multiple masculinities and femininities recognized by more recent social scientific research (Connell, 2002). Epidemiological research shows that certain groups of men and certain groups of women are more at risk of attempting suicide than others. In order to understand and address suicidal behaviour, it is necessary to review what is known about the types of men and women who are at risk and the social context in which they live.

This article does not constitute a systematic review of relevant literature. It is, however, informed by thorough searching. A key starting point for searching was the Hawton and van Heeringen (2000) *Handbook*, which provided both recent reviews of some important research areas and also reference to research studies that were worth following up in detail. We also conducted searches in Web of Science and Medline (since the conscious focus was on medical and psychological papers that a social work readership may not be familiar with). Search terms included 'suicide', 'self-harm', 'suicidal behaviour', 'youth', 'young people', 'adolescents' and some more specific terms where relevant literature was not so immediately forthcoming, such as 'help-seeking' and 'sexuality'. We review research from across the Western world, recognizing that there is significant cultural variation across the globe (see, for example, Cheng and Lee, 2000) that we cannot do justice to in one article. Most of the more specific points of policy relate to England and Wales, however, which is the context we know best.

Employment

Local authority areas with significantly high suicide rates tend to be those which are characterized as having high levels of deprivation (Bunting and Kelly, 1998; Hearn et al., 2002). One important indicator of social deprivation is unemployment. Platt and Hawton's (2000) systematic review shows convincingly the link between unemployment and suicide. To address the UK context specifically, the shift in the socio-economic infrastructure of the UK from heavy industries towards more service and information sectors has meant a move away from occupations traditionally seen as 'masculine' (such as manufacturing), towards the increase of traditionally 'feminine' jobs (such as the service industry). The rise of the service and information sectors has brought increased employment opportunities seen as more relevant to women than to men. These changes have resulted in higher unemployment rates for men, with young men under 25 particularly at risk of being out of work. This is pertinent insofar as young men appear to be more vulnerable to the stressors associated with long-term unemployment (Albizu-Garciaa et al., 2001). The association between unemployment and suicide is complex (Lewis and Sloggett, 1998). As Stack (2000) comments, the risk lies not simply in being out of work but rather in its effects in 'eroding the incomes, economic welfare, (and) self-esteem' of unemployed people.

Although there has been some debate about the nature of the link between employment and suicide (see below), there does seem to be a consensus that occupational factors are of particular importance for men. The increase in occupational instability, with a rise in temporary and contract work, has been put forward as a factor in the recent increase in male suicide rates (Hawton, 2000). For adolescents, the changing socio-economic infrastructure has provided a challenging environment in which to undertake the transition from education to employment. Of particular concern has been the emergence of what Rees et al. (1996) have termed 'Status Zer0 Citizens' where school leavers aged 16–17 fail to join training schemes, enter post-16 education, or find employment. For these young people who fall outside the mainstream, the effects of unemployment on health may be mediated by financial problems and pessimism about the future (Novo et al., 2001).

The relationship between unemployment and suicide is not at all straightforward. Rising employment under the UK New Labour government, whilst potentially having a generally positive effect on mental health, may not directly reduce the suicide rate for young people. Other factors of a more cultural nature, such as the gendered meanings given to work and non-work by young men and women, may be more influential. Crawford and Prince (1999) argue that it is the meaning of what it is to be without work that is of importance, with those still unemployed in times of high employment experiencing the greatest pressures. In their study of men aged 15–44 from 364 English county districts, they found the greatest increases in the rates of suicide for men in those districts

that experienced the largest *fall* in unemployment and largest rise in car ownership, and also had the largest proportion of people living alone. It seems that when unemployment levels drop there is greater pressure placed on those still out of work.

Evidence on the relationship between employment and suicide is therefore complex. Whilst there is evidence to suggest a link between higher suicide rates and deprivation, there is also evidence that young men are at risk in localities whose socio-economic profiles are generally improving. We might conclude that the effects of unemployment on young men's mental health can be very serious, and that these effects may be more acute where the quality of life in the surrounding community is improving. The policy implication of this is therefore not simply the generation of more jobs, although full employment would probably improve mental health. Rather there is an issue of the priorities and expectations of young men. We do not suggest that young men should be encouraged to welcome unemployment. However, education in schools and communities could aim to offer wider conceptions of appropriate roles for young men, including roles outside the formal labour market (such as caring for children or adult relatives). Less emphasis on the necessity of paid employment for transition to manhood would mean less pressure on those who fail to conform to this pattern. This is certainly an issue for social work practitioners to consider when doing case work or group work with vulnerable young men.

Social Cohesion and Social Comparison

This section will deal with the types of society that might be more associated with suicide, and particularly how young people regard their social context. There will be discussion firstly of social cohesion and fragmentation and secondly of comparative happiness and quality of life.

Social cohesion and its opposite, social fragmentation, are concepts that have been associated with sociological research on suicide ever since Durkheim (1897). Whitley et al. (1999) recently explored the relationship between social fragmentation and suicide in the UK using Congdon's (1996) 'anomie' score. This was derived from four census variables: population turnover, proportions of single person households and non-married adults, and people living in privately rented accommodation. Whitley et al. observe that areas with the greatest increases in social fragmentation also had the greatest increases in suicide. It remains possible, of course, that high-risk individuals choose to live in areas with high social fragmentation in the same way that poor mental health may be a *cause* of unemployment as well as a symptom (Platt, 1984: 95). Obviously, the inclusion of single person households and non-married individuals as measures of social fragmentation has to be questioned. If living alone is becoming even more of a mainstream lifestyle (a third of all households in the UK, according to the 2001 census) then it need not necessarily suggest fragmentation. The avoidance of marriage by heterosexual couples and the increasing

acceptance of lesbian and gay lifestyles can also be understood as more general shifts in patterns of intimate relationships, rather than part of a problematic 'fragmentation'.

Research on social cohesion suggests that successful regeneration and community development strategies could potentially have a positive effect on reducing suicidal behaviour. There is, however, little evidence to date. Huxley and colleagues have reported findings from a large research project on the effects of community regeneration on mental health (Huxley and Evans, 2001; Huxley et al., 2004). They found that where most change in quality of life occurred – in housing improvements – the residents did have a greater sense of financial well-being, physical health and quality of life than the residents in the area of comparison. However, these changes did not appear to have any impact on mental health. These research findings do not inspire confidence in the effectiveness of regeneration strategies, but as Huxley and Evans admit, two years is perhaps too short a period for a positive impact to be observed. Mitchell (2000: 72–3) describes community development initiatives sponsored as part of the National Youth Suicide Prevention Strategy in Australia. She rightly distinguishes community development initiatives that are designed and owned by community members from expert-led community support projects, which are not. She argues that there is an important role for community development in avoiding the imposition of culturally inappropriate services on minority groups. Examples Mitchell gives include the Here for Life Youth Sexuality Project with lesbian and gay youth in Western Australia and the work with indigenous people in Yarrabah in far North Queensland.

Related to social cohesion and fragmentation is the question of how people perceive their community and wider society. Particularly important here are comparisons young people make in terms of the perceived happiness of others and quality of life. Barber (2001) has recently examined the 'absolute misery' hypothesis. This regards rising suicide rates as a valid indicator of increasing social maladjustment (general unhappiness) in the general population of young people. His analysis of seven countries shows that young men's suicide does not in fact support the absolute misery hypothesis. Indeed, higher rates of male suicide were associated with *higher* levels of psychological adjustment among the general adolescent population. Whilst female suicide rates seem to support the absolute misery hypothesis to some extent, Barber's interpretation is that men tend to make social comparisons with the situations of others by perceiving themselves to be not as happy as their peers. He proposes a 'relative misery' hypothesis where suicidality is related to upward social comparison which requires a level of psychological maladjustment and the perception that one is worse off than one's peers. This fits to some extent with Crawford and Prince's (1999) research showing that there is greater pressure placed on men who are still out of work when general employment levels are improving.

Lester (1998) also makes a somewhat similar observation, suggesting that suicide is linked to social comparison in the context of generally improved

quality of life. Lester draws on Henry and Short's (1954) theory of suicide. These authors argue that when external conditions are bad there is a clear source of blame for personal misery. In contrast, when times are good and the quality of life improves, individual men and women are more likely to blame themselves if they are unhappy. Lester argues that in a context of improved quality of life (that is constantly reinforced by media images), adolescents who have not achieved success will become acutely aware of their failure and internalize blame.

These findings on social comparison are important for the messages that social workers and others give out in case work and group work with young people in distress. There is scope for workers to promote the idea among vulnerable young people that however seemingly successful and confident their peers may be, they may also have problems and may suffer from doubts, anxieties and low mood.

Mental Illness

This section reviews some research evidence on the nature and extent of mental health problems in suicidal young people and the gendered responses of young people to mental health problems. Evidence about the risks to mental health service users is also presented.

According to research by Flisher (1999), almost all adolescents dying by suicide show evidence of suffering from some form of mood disorder. In his review of seven different psychological autopsy studies of children and adolescents, Flisher found some evidence that depression was higher in female suicide and that dysthymia (a mild, but chronic, form of depression) was more prevalent in male suicide. However, Flisher argues that while suicide and depression are clearly linked, it is difficult to ascertain whether depression *causes* or is *caused by* suicidal thoughts and feelings.

Houston et al. (2001) identified the presence of untreated depressive disorders and personality disorders within their sample of young suicide victims aged 15–24. They found co-morbidity of psychiatric disorders in a third of their sample. Again, it is not possible to determine whether they are a symptom or a cause of suicidal behaviour. The English Department of Health's *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (DH, 2001) reported that a third of the under-25s who killed themselves were suffering from schizophrenia, whilst a fifth were given the primary diagnosis of personality disorder. In addition, they found that most people with schizophrenia were both unemployed and unmarried, with younger suicides also being more likely to have a history of substance or alcohol abuse and violence. Interestingly, the National Inquiry found suicides to be clustered in the first year after the onset of illness, which serves to reinforce the association between suicidal behaviour and mental illness.

Although there is a clear link between mental health/illness and suicide risk,

the relationship is a complex one. In reviewing the psychosocial problems of young people in Australia between 1964 and 1997, Lynskey et al. (2000) found that there had been an apparent increase in the rates of psychosocial disorders, and that these increases were consistent across men and women. Despite this, however, suicide rates for men rose while suicide rates for women remained relatively static, suggesting that it is the gendered experience of mental illness and the gendered response of sufferers that need to be understood in order to prevent suicide.

The experience of mental illness and service use is, of course, heavily gendered (Prior, 1999). Langhinrichsen-Rohling et al. (1998) suggest that there are gender differences in depression, with females socialized to express their dissatisfactions: depressive symptoms appear as a result of this process. These authors also suggest that young men are taught to assert their independence and prove their masculinity by engaging in risky behaviours and displaying their physical prowess. Using a sample of 769 adolescents and young adults, Langhinrichsen-Rohling et al. (1998) found that although women reported more symptoms of depression, male and female adolescents did *not* differ in their scores on the measure of *hopelessness*. Langhinrichsen-Rohling et al.'s findings distinguished between male and female adolescents' expression of various suicide-related behaviours. Males were found to have more negative health-related behaviours and to engage with more impulsive and risky activities than females. Whilst females tended towards more depressive symptoms, males were found to score much higher on the impulsive life-threatening behaviour scale. As Langhinrichsen-Rohling et al. note, these findings are of particular importance. Not only do they represent one of the few measures of suicidal ideation in which men score higher than women (most research finds suicidal ideation to be higher in women), but they do so on a measure initially designed for its non-significant associations with gender.

The differences found between suicidal men and suicidal women tend to suggest that suicidal women suffer more from anxiety disorders and panic disorders than do suicidal men. Suicidal men tend to show higher rates of addictive disorders (Albizu-Garciaa et al., 2001; Prior and Hayes, 2001; Wunderlich et al., 2001). As Wunderlich et al. (2001) have noted, drug and alcohol use can help to anaesthetize unpleasant feelings and prevent the early stages of depression becoming visible. It is possible that male adolescents tend to use substance abuse as a means of repression. The effects of substance abuse upon consciousness can result in damaged social relationships, and poor work performance, personal care, and general health (Murphy, 2000). Young men appear to be particularly vulnerable to the loss of close personal relationships, with half of the alcoholics identified by Murphy having experienced loss within the year prior to death.

Predominant characteristics of substance-abusing suicide attempters include being male, having a history of criminal offences, being unemployed, and living alone. Substance-abusing attempters tend to have high levels of

repeat attempts (Murphy, 2000). Findings from the English Department of Health's National Inquiry (DH, 2001) suggest that substance misuse can obstruct professionals from perceiving the risk of suicide. In 6 per cent of the final appointments before suicide, patient requests for increased or altered medication were not followed by professionals, due to the belief that the patient's immediate problem was that of alcohol or drug misuse. The National Inquiry goes on to report that in around a quarter of the sample, clear evidence of relapse in mental health was noted three months before suicide, with almost half of those who killed themselves displaying 'proxy indicators' including increased alcohol or substance misuse. This was more prevalent among youth suicides. It appears that substance misuse can be both a problem itself and a sign of problems: the principal difficulty is one of diagnosis. As such, the National Inquiry recommends increased staff training including risk management as well as closer collaboration between mental health teams and substance misuse services where dual diagnosis is present.

Mental health teams contacted through the National Inquiry often felt that suicide was preventable, with young patients, in particular, failing to comply with medication (DH, 2001). Moreover, the mental health teams called for closer contact with patients' families, closer patient supervision and better staff training as important factors in preventing suicides for those known to the mental health teams. For those who were known to the services but who missed contact, significant differences were found: those who were unmarried, unemployed, or living alone were more likely to miss appointments. In response to this, the National Inquiry recommends that action is taken where patients fail to attend appointments and suggests that assertive outreach teams are available to maintain contact with vulnerable and high-risk patients.

Despite the evident risks to people who are users of mental health services, it should be noted that of the 20,297 suicides and probable suicides investigated for the National Inquiry, only 5,099 were known to be in contact with mental health services in the year before their death. Thus, only a quarter of all suicides in England and Wales had been in touch with mental health services, representing 1,500 cases a year (DH, 2001).

Brent and Moritz (1996) suggest that young men are at particular risk of suffering from co-morbid affective and substance abuse disorders. However, as this section of our article has illustrated, it is difficult to ascertain the exact nature of the relationship between mental health problems, substance abuse and suicide. The research evidence appears to suggest that whilst women tend to suffer more anxiety and panic disorders, men display higher rates of addictive disorders. The effects of substance abuse may mask affective disorder symptoms as well as damaging social relationships and physical health. As such, substance abuse may serve both as a problem and as a sign that the individual is experiencing problems in addition to the addiction.

The research findings summarized in this section have implications for case management in social work. There needs to be more awareness of the

relationship between substance misuse and other mental health problems (through training and developments in risk assessment) and attention needs to be paid to inter-professional working in the related but often separate sectors of substance misuse and mental health services. There also needs to be increased attention to following up missed appointments.

Family and Relationships

Whilst a great deal of research into youth suicide has focused upon such factors as unemployment, deprivation, substance abuse and psychosocial disorders, the influence of family life has perhaps been less well documented. Houston et al. (2001) conducted a psychological autopsy study on the suicides of young people and found that a quarter of their sample had experienced family instability or poverty. In addition, a quarter had been exposed to the suicidal behaviour of a relative. This research suggests that for older adolescents and young adults, suicide was the result of long-term difficulties experienced in early adolescence or childhood (see also Harrington, 2001).

Wannan and Fombonne (1998) found that family functioning was a more important factor than family structure. Suicidal behaviour was influenced not by the presence or absence of two parents but by adult relationships. Wannan and Fombonne propose that this influence could involve either a lack of support or a directly stressful effect upon adolescents. This proposition echoes the views of young people themselves. Coggan et al. (1997) conducted focus groups with young people who stressed the importance of family support and knowledge when faced with emotional distress. Focus group participants also talked about the overprotective and judgmental approach of many parents. They suggested that in times of crisis young people wanted to be loved unconditionally and not judged for their feelings.

Although parental care has traditionally been more strongly associated with femininity and mothering, the gendering of care within the family is in fact a more complex phenomenon (Morgan, 1996). It would appear that gender differences emerge in both parenting approach and the parental preference of young people themselves, though findings have varied between studies as to the nature of these differences. Klimes-Dougan (1998) found that mothers underestimated their children's suicidality, and were more sensitive to their daughters' thoughts and behaviours than those of their sons. However, in Paterson et al.'s (1994) research, adolescents of both sexes reported that they interacted with their mothers more often than their fathers, and also perceived their fathers to be less emotionally involved than mothers when asked to help. When asked to judge how well their parents knew them and cared for them, Youniss and Ketterlinus (1987) found that adolescent girls thought that their mothers knew them better than their fathers knew them, and adolescent boys felt that both parents knew them equally well. Schonert-Reichl and Muller's (1996) study of 221 adolescents found that adolescent males were more likely to turn

to their fathers for support, whilst no difference was found for adolescent females.

Young men appear to be particularly vulnerable to a lack of emotional support; a notion supported by the well-documented protective effects of marriage on the health of young men (Kelly and Bunting, 1998). Divorced and widowed men and women have higher rates of suicide than those who are married (Gunnell, 2000). Stack's (1998) study of marriage and suicide susceptibility across 15 nations demonstrated that while marriage does lower susceptibility in both sexes, the association is far stronger in men. Fowers (1991) found that men report greater satisfaction with marital life. Men have been found to experience less loneliness (Gove and Geerken, 1977) and higher levels of physical health from marriage (Ross et al., 1990) than women. The obvious feminist interpretation of this is that the division of both physical and emotional labour in marriage is still largely traditional, with men getting a better deal than women. It is perhaps not surprising then that Cantor (2000) suggests men are especially 'brittle' to the consequences of relationship breakdown and vulnerable to separation. As we have already noted, the suicide rates for single men have been increasing since 1993 (Kelly and Bunting, 1998). It has been suggested that the socio-cultural changes in the dominant roles for women are making it easier for young women to leave unsatisfactory relationships (Hawton, 2000), leaving increased numbers of men living alone: a consistently reported risk factor in youth suicide (Crawford and Prince, 1999; DH, 2001; Hawton et al., 2001).

Policy intervention surrounding the family could involve measures designed to increase family stability. Rather than an impulsive, emotion-driven act, suicide is often the end result of a long history of difficulties. Young people appear to need emotional support, which may be encouraged by providing parents with appropriate information and guidance on how to approach their children if they are concerned about their behaviour, how to provide social support, and how to identify the warning signs of self-harm.

Initiatives in family support could potentially have a positive effect on reducing suicide rates. There may be potential for pre-school family support programmes such as Sure Start in the UK to impact on the future mental health of parents and children. Inevitably, interventions in families are politically highly charged. There are contentious issues at every turn. For example, encouraging women to stay in relationships to avoid the negative effects of separation on men could have a negative effect on the women's own mental health. Instead, a broader social policy response might include more education for boys and young men about changing conceptions of masculinity in families. Social work practitioners also need to consider this perspective when working with men in a family context.

There seems to be potential for brief family interventions by social workers to have a positive impact on suicidal thoughts in some young people. Harrington et al. (1998) conducted a randomized-controlled trial of family-based brief

social work interventions with young people who had previously taken overdoses. This found the intervention to have some success in reducing suicidal ideation in young people *without* major depression.

Sexual Orientation

Issues of sexuality and sexual orientation emerge strongly in adolescence (Bagley and D'Augelli, 2000) and lesbian, gay and bisexual (LGB) activities are strongly associated with increased risk of suicide (Fergusson et al., 1999). According to Tremblay (1995) a suicide problem can be seen in LGB communities over the last 150 years. However, it is gay and bisexual men in particular that have been found to be at an increased risk of suicide (Remafedi et al., 1998). In terms of suicidal ideation, lesbian and bisexual women tend to express a greater desire to hurt themselves, while gay and bisexual males tend to report feeling that they wanted to be dead (D'Augelli et al., 2001). When LGB young people attempt suicide, their attempts tend to be more severe and lethal than those of heterosexuals (Kourany, 1987).

The reported rates of LGB suicide vary but tend to be in the range of 20–42 per cent of young bisexual and homosexual research volunteers (Remafedi, 1999). For example, the population-based study by Remafedi et al. (1998) compared 394 LGB high school students with 336 matched heterosexual students in order to identify the relationship between sexual orientation and suicide attempt. They found that 28 per cent of gay and bisexual males reported a suicide attempt compared to 4 per cent of heterosexual males. The difference for females was not as marked: 20 per cent of lesbian and bisexual females reported an attempt compared to 14 per cent of heterosexual females.

The mean age of first same-sex activity is 13 for boys and 15 for girls, and boys also tend to 'come out' earlier than girls (Savin-Williams, cited by Morrison and L'Heureux, 2001). Coming out is associated with an increased risk of suicide. For both those who come out at an early age and those who do not come out at all, high levels of isolation are experienced. For example, a young person who is out is at risk of harassment or assault and so may experience psychological isolation. Also, a young person who is not 'out' may experience isolation associated with being unable to share their identity with those around them (Remafedi et al., 1998; Morrison and L'Heureux, 2001). The combination of early same-sex activity and coming out means that school-based suicide prevention is particularly pertinent for LGB adolescents. Unfortunately, however, until recently Section 28 of the Local Government Act 1988 prevented local authorities in the UK from intentionally promoting homosexuality as 'a pretended family relationship'.

In addition to the problems that were generated by Section 28, many teachers and health care providers are often unaware of LGB issues and lifestyles and adopt a 'heterosexual' outlook (Morrison and L'Heureux, 2001). This heterosexism involves the normalization and endorsement of

heterosexuality (Herek, 1992). LGB youths are accustomed to the use of words such as 'fag' and 'dyke' within the secondary school environment (Bagley and D'Augelli, 2000). Non-conformity to dominant masculinities and femininities can lead to social exclusion as well as psychological and physical persecution (Bagley and Tremblay, 1997). Compared to young lesbians, young gay men experience particularly high levels of victimization and negative attitudes (Pilkington and D'Augelli, 1995). Young people do not in fact have to be lesbian, gay or bisexual to experience homophobic bullying. Rivers (quoted in Berliner, 2001) suggests that any young person who does not conform to gender norms current in their school may fall victim.

In response to the prevalence of bullying within education, the anti-bullying pack *Bullying: Don't Suffer in Silence* (DfES, 2001) has been introduced in England. This pack is aimed at providing schools with clear guidelines on how to recognize and deal with homophobic bullying. It calls for greater awareness of discrimination among pupils so that they understand what it is and the school will act upon it. It notes that pupils should be encouraged to explore diversity and difference as a means of preventing discrimination. In direct reference to homophobic bullying, the DfES stipulates that schools should provide confidential and appropriate advice to lesbian and gay pupils and that teachers should receive training during INSET days. Finally, the DfES recommends that pupils should be made aware of their use of homophobic language and its possible impact upon others.

The relationship between suicidality and sexual orientation involves a number of risk factors. Issues around 'coming out' include gender non-conformity (transgressing tacit rules about appropriate behaviour for young men and young women) and adverse reactions from family and peers (Remafedi et al., 1998; Bagley and D'Augelli, 2000). Young people can also find that negative emotional reactions follow their identification with a stigmatized sexual orientation (Fergusson et al., 1999). Non-disclosure of sexual orientation to others can also be a risk factor. All of these factors tend to share one common component, that of isolation. Isolation can potentially be tackled through initiatives to challenge homophobic bullying and through the development of services for LGB young people. Morrison and Garthwaite (1999, cited by Morrison and L'Heureux, 2001) have shown that when offered an 'affirming youth agency' 82 per cent of their sample of LGB young people felt less isolated and 78 per cent stated that they had felt supported when coming out.

In terms of future policy development, a welcome first step would be the wider official recognition that lesbian, gay and bisexual young people are at high risk of suicide. At present, there is no such recognition in important policy documents such as the *National Suicide Prevention Strategy for England* (DH, 2002). In terms of case work with young people, an obvious implication of the research reviewed in this section is that social workers should avoid talk which implies an assumption of heterosexuality, and should make it clear that open discussions of sexuality are welcomed within the social work relationship. This

may be basic anti-discriminatory practice, but is worth re-asserting in this context.

Help-seeking

According to the English Department of Health's National Confidential Inquiry (DH, 2001), around 1,500 suicide cases per year are known to mental health services prior to suicide. This represents only a quarter of all the deaths recorded as suicide or 'open verdict' (DH, 2001). Similarly, Booth and Owens (2000) estimate that between 65 and 86 per cent of people who kill themselves are not in contact with services. Cohen suggests that for some, asking for help involves '. . . suffering, soul-searching, and a major emotional effort to overcome a wide range of social and psychological obstacles that may, in the end, preclude the articulation of the request and the subsequent receipt of assistance' (Cohen, 1999: 67). The following section will review what is known about those who do not seek help as well as the known characteristics of those who do.

Handwerk et al. (1998) investigated the lethality of attempted suicide and prior suicidal communications in adolescents aged 10–18 years. They found that 20 per cent of their sample had made no prior communication to service providers. A further 20 per cent made only one suicidal communication prior to attempting suicide. Attempts made after one communication tended to involve more lethal methods than attempts after multiple communications. The authors suggest that screening mechanisms are needed to identify adolescents who are at risk, to include those who present suicidal ideation and those who do not. Interestingly, Handwerk et al. also found that the low communication group was more likely to have a history of drug abuse. It is therefore possible that the low communication group adopted an incommunicative coping style as illustrated by the higher rates of drug misuse among the non-communicators than the high communicators (65 and 23 per cent respectively). There was possibly more internalization of problems among the drug using/low communication group. Attention needs to be paid to identifying risk factors such as drug use (Burns and Patton, 2000) as well as to providing an immediate response after an initial communication about suicide has been made (Handwerk et al., 1998).

Gender differences emerge clearly within help-seeking behaviours. Men are generally less likely than women to disclose suicidal thoughts, less likely to ask for help when they have an emotional problem (Meltzer et al., 2002), and more reluctant to discuss their emotional problems generally (Hawton, 2000). Moreover, when men do seek help, they seem to do so as a result of a more negative perception of their mental health as well as having more severe mental health problems before they will access help sources (Albizu-Garciaa et al., 2001). Research on help-seeking in adolescents suggests a similar pattern. Schonert-Reichl and Muller's (1996) study of 221 10–18-year-olds found that girls reported seeking help more often than their male counterparts. Young women sought help from both formal networks (such as teachers or mental

health professionals) and informal networks (such as parents or peers) more often than young men. In contrast, 85 per cent of the male sample reported that they would not seek help from friends, and the middle adolescent boys (aged 15–18) were more likely to turn to their fathers for advice during later adolescence (45 per cent). Schonert-Reichl and Muller suggest that this might have been due to the perception that their fathers have had similar experiences and, as such, could offer advice.

Dubow et al. (1990) found that one of the most common reasons given by adolescents for not seeking help was that they considered that the problem was too personal to talk to others about. Ciarrochi et al. (2002: 174) refer to the ability to identify, describe and understand emotions as 'emotional competence'. In a study of 137 young people aged 16–18, they found that adolescents who were low in emotional competence were less likely to seek help from non-professional sources (e.g. family and friends). Ciarrochi et al. suggested that adolescents who were low in emotional competence were too embarrassed to seek help. Interestingly, adolescents low in emotional competence did not have lower intentions of seeking help from professional services (e.g. mental health professionals, phone helplines, doctors/GPs). Ciarrochi et al. suggested that these adolescents might feel less embarrassment about appearing emotionally confused or inadequate to professionals, compared to people they knew well.

The more general picture is, however, that many young people do not seek help from formal services at all. West (cited by Armstrong et al., 2000) suggests that up to one in five young people experience significant mental health problems, yet many do not seek help. There may be a variety of reasons for this. Embarrassment and stigma in accessing services may be one factor. Jacobson et al. (2001) note that young people often feel uncomfortable both making an appointment and visiting their doctor and even when young people do access services they experience difficulties in articulating their feelings.

Clearly, accessing professional services presents a considerable obstacle to young people seeking help for their problems. Coggan et al.'s (1997) focus groups demonstrated that young people continue to have difficulty with services even after they have successfully made contact. For example, these authors report that young people tended to perceive consultations with their GPs as too short and based upon a diagnosis rationale. Those who were referred to psychiatrists and psychologists felt that they had been made to wait too long for an appointment and that the service was largely impersonal. The dissatisfaction that young people may feel with professional services is reflected in the number who do not comply with the prescribed treatment programmes or who fail to attend subsequent appointments (Rudd and Joiner, 1998). Given that half of all successful suicides have previously made failed attempts (Gunnell, 2000), non-compliance is an important factor in suicide prevention strategies. Foster et al. (cited by Higgitt, 2000) reported that one in four of successful suicide attempters who were not known to mental health teams had attended an Accident and Emergency Department within the previous year. Around half of

those who do attend the Accident and Emergency Department following deliberate self-harm are discharged without having been subject to a psychosocial assessment (Kapur et al., cited by Higgitt, 2000).

Boergers et al.'s (1998) study of adolescents who had attempted suicide suggests that half of the sample had wished to die, escape, or obtain relief from their emotional distress. Only 18 per cent reported having used self-harm as a means of securing help: relatively few attempts could therefore be labelled as a 'cry for help'. Boergers et al. suggest that adolescent suicide attempters might be more willing to engage in treatment if staff placed an emphasis on helping them to obtain relief from their distress rather than treating the attempt as a cry for help. This has important implications for service providers. Wilson and Deane (2001) stress the need to establish trusting relationships with young people that allow the young person time to broach often painful or distressing problems. Wilson and Deane's research also supports Schonert-Reichl and Muller's (1996) finding that adolescents prefer to talk to adults or professionals who have experienced similar problems and are able to discuss how to resolve the problem in practical rather than theoretical terms.

The general picture seems to be that many young people do not seek help in times of distress. Embarrassment, stigma, and the relative novelty of discussing intimate feelings with strangers serve to deter young people. Those who do articulate their suicidal thoughts may be dismissed as attention-seeking. Intervention programmes should therefore state explicitly that all suicidal communication or behaviours must be taken seriously, and greater efforts need to be taken in making service providers accessible to young people.

Hawton (2000) suggests that the reluctance of young men to share emotional problems calls into question the straightforward use of 'talking therapies'. Rather, he suggests that men may respond to more practical problem-solving techniques before talking is introduced. This supports the idea already outlined that both young men and young women prefer the opportunity to build relationships with help providers before they begin to talk about their personal issues. Yet many formal services are simply not able to provide young people with the appropriate amount of time due to their workloads and the use of formal appointment systems. It is possible that more informal 'drop-in' services would be beneficial to the emotional well-being of adolescents. Offer et al. (1991) agree with the need for informal drop-in centres, since more 'disturbed' young people are more likely to make use of these types of services. Also, since many young people will turn to friends and family for help rather than contacting formal services, the development of lay referrals may prove beneficial. This development could be initiated by, for example, parental training.

Conclusion

Our aim in this article has been to summarize the findings of recent research on the social context of suicide in young people, with a particular focus on issues

of gender. We have concentrated on research published in medical and psychological journals that social work practitioners and academics are less likely to be familiar with. Although this work has been carried out by medical and psychological researchers, the papers we review have important messages about the *social* context of suicide. We have commented along the way on possible implications for social policy and for social work practice. We conclude by reiterating the clearest messages from the research reviewed.

Of all the aspects of the social context of youth suicide, one of the most significant and also one of the most obviously gendered is the effect of unemployment. The relation between suicide and economic deprivation is complex: although suicide rates are associated with deprivation, there can also be more pressure on young men when unemployment is low. There is evidence that young men in distress make social comparisons with their apparently more happy and successful peers. The social meanings attached to work and the association between hegemonic masculinity and working is particularly important. These should be addressed when educating boys, and during social work with vulnerable boys and young men. The effect of social comparison on mental health should be more generally borne in mind by social workers in their case work with distressed young people. Social fragmentation is another important aspect of the social context of suicide that community regeneration and community development could potentially have a positive impact on, although evidence to date is lacking.

The management of young people with mental illness has implications for suicide prevention as it does with all adults. Substance misuse in young men is a particular issue in relation to suicide, and issues for social workers include inter-professional working across the boundaries of mental health and substance misuse services, risk assessment and following up failed appointments. Research also emphasizes the importance of family members for support, and the vulnerability of young men in particular to relationship breakdown. These suggest the need for improved family support, including interventions that involve fathers. Education for boys on maintaining positive and equal relationships could also be considered. Lesbian, gay and bisexual young people in general are more vulnerable to suicide, and young men especially. This is clearly a gender issue insofar as the pressure relates to the constraints of traditional gender roles and compulsory heterosexuality. Greater recognition of the problem of gay suicide is needed, and there are various possible implications for social workers, such as the importance of making it clear to young people that open discussion of sexuality (and not just heterosexuality) can be part of the social work relationship. Research on help-seeking tends to suggest that talk of suicide from young people must always be taken seriously and services can be improved to make them more approachable for young people, and young men in particular.

We have argued that self-harming behaviour is rooted in social context. In this way, we believe that social work and social policy interventions are

paramount. Sharpe et al. strongly argue the case for social responses on the basis of their research into self-harm on a deprived estate in Edinburgh:

> (T)his behaviour is not a defining characteristic of their lives. Rather, it should be seen as a by-product of a life beset by multiple problems and a range of self-damaging behaviours. The social context is a physical, interpersonal and social environment that amplifies (rather than alleviates) the manifold difficulties experienced by troubled and vulnerable individuals. (2000: 14)

Given the importance of the social context, we regret that the Department of Health's *National Suicide Prevention Strategy for England* (DH, 2002) does not consider the potential impact of macro-level social policies on suicide. These policies might include poverty reduction and community development, as well as the education of children to challenge damaging gender stereotypes.

Finally, we would like to point to some gaps in the current research on suicide in young men and women. Hawton (2000) provides a useful summary to date. There has been relatively little research on gender differences in relation to factors that prevent suicide, or in relation to how people at risk of suicidal acts respond to treatments. Hawton argues that further epidemiological studies are needed to disentangle the gendered social and economic factors associated with suicide. We would also argue that more qualitative and sociological research on cultural factors is also needed in addition to the large body of quantitative research from epidemiologists and psychologists.

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