"If You Were Like Me, You Would Consider It Too": Suicide, Older Men, and Masculinity

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Abstract

Rates of suicide are far higher for older men than for any other age or gender group. However, we know relatively little about how depressed older men think about suicide. This study addresses this gap by exploring how Latino and white non-Hispanic elderly men discuss why they would or would not contemplate suicide. Men, aged 60 and older, were screened and assessed using standard instruments for clinical depression. Those meeting criteria were invited to participate in a 1.5 to 2.5-hour in-depth interview, in either English or Spanish. Interview data come from 77 men and included men with treated and untreated depression. Men linked depression to losing their economic role, sense of productivity, and familial respect. Their narratives of suicide highlighted central tenets of hegemonic masculinity. Men from both ethnic groups asserted that "being a man" involved strength and independent choice. For some men, suicide exemplifies these ideals; for most men suicide violates them. The majority of men who felt that suicide further violated their already fragile manhood either reclaimed a decisive masculine self or embraced a caring self, especially in relation to children and family. The latter pattern raises a theoretical question regarding the symbolic boundaries of hegemonic masculinity.

Keywords

suicide, masculinity, older men, self, emotional suffering

The epidemiological data on suicide have been quite consistent throughout the 19th and 20th centuries. With the exception of China's, data from across the globe continue to show that men have higher rates of suicide than do women (Bertolote and Fleischmann 2002; National Center for Injury Prevention and Control 2016; World Health Organization 2001). In the United States white men exhibit higher rates than nonwhite men, with those 65 years of age and older completing suicide eight times more often than any other group (Sachs-Ericsson, Van Orden, and Zarit 2016). Further, men older than 75 years are at the highest risk of suicide in the United States (Centers for Disease Control and Prevention 2015). Depression, one of the strongest risk factors for suicide-related behavior (Crump et al. 2014), is more commonly reported in older women than in older men

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(Charney et al. 2003; Unützer 2007), and older men experience substantially lower rates of treatment for depression than do older women (Hinton et al. 2006).

There are also differences between men and women regarding suicide attempts. In most countries men die by suicide at higher rates while women attempt suicide at higher rates (Kerkhof 2000; Mann 2002). Notably, women's attempted suicide rate appears to decline with age, whereas men's suicide rate rises with age cohort. Men are more likely to use a method that is more lethal, and they seek to avoid detection, whereas women tend to use less lethal means in attempts that are more likely to be discovered (Mann 2002). These lethality and intention aspects of men's and women's suicidal behavior indicate significant gender differences in how men and women view suicide and its consequences. If women's attempted suicide may be seen as an "appeal for help" (Mann 2002:303), might older men's suicides be seen as a statement—but a statement of what exactly?

Our research seeks to address this question based on in-depth interviews with 30 Latino and 47 white non-Hispanic (WNH) predominantly working-class older men who were screened for depression, an age group that has been understudied despite the members' being at the highest risk for suicidality. As Evans et al. (2011:12) point out, "the lives of older men remain mostly unexplored, 'so much so that older men have been categorized as 'invisible' men in contemporary society." We hope to remedy this in part by examining how older men talk about suicide in relation to the intersection of masculinity and emotional suffering. Harwood and Jacoby (2000:288) note that "both physical illness and depression are often present in older people who die through suicide. However, both these problems are not infrequent in the older population, and the interesting question is why some people with these problems choose suicide, and some maintain a will to live." In the same vein, despite the significant difference in older men's and women's suicide rates, Stanley et al. (2016) never address gender in their otherwise useful review of psychological and sociological theories of why older adults commit suicide. Likewise, this work has not addressed how, if at all, views of suicide intersect with conceptions of masculinity in the context of ethnicity and social class. We argue that a sense of loss (physical, economic, and social) characterizes older men's narratives but that this loss is gendered

and linked to their views on suicide. Some older men's views of suicide reflect a masculine ethos that has been undermined. Yet for other men, suicide represents the antithesis of masculinity, and they reverse the gender codes in ways that reject suicide. Further, our interviews suggest that the view of fatherhood of those who opposed suicide marked a selective reconstruction of hegemonic masculinity, thus providing further evidence of its malleability and durability.

MASCULINITIES, MEN'S HEALTH, AND SUICIDE

There are various explanations of suicide's connection with gender, social order, and mental and physical health (Canetto and Sakinofsky 1998). Scholars have proposed that there are both benefits and serious costs or "hazards" to having male privilege (Canetto 1995; Jaworski 2014; Joiner 2011). While men who are married are at lower risk for suicide, typically women's "relative immunity" from suicidal behavior has been explained by their lack of full participation in mainstream social institutions, limited autonomy, and primary roles in the domestic social order (Stack 2000a). Some authors have argued that this dominant explanation is misguided (Berkman et al. 2000; Douglas 2015; Zhang 2016), and given the substantial changes in men and women's participation in the labor market and the domestic spheres, especially in the post-1950s United States, others have called for a more critical analysis of gender, emotional suffering, and suicide (Kposowa 2000; Payne, Swami, and Stanistreet 2008; Shiner et al. 2009).

A fruitful line of inquiry in this regard has focused on how men experience depression and specifically how their accounts of it are related to their understanding of masculinity (Addis 2008; Emslie et al. 2006; Galasinski 2008; O'Brien et al. 2005; Ridge et al. 2011). Studies of men's narratives of depression based on interviews point to how norms of masculinity may lead men to "mask" their depression or self-medicate through alcohol or substance use (Courtenay 2000; but see also Addis 2008), complicate their help-seeking efforts (O'Brien, Hunt, and Hart 2005), or reconstruct/resist hegemonic masculinity (Emslie et al. 2006). For example, in his nuanced sociolinguistic discourse analysis of a small clinical sample of Polish men receiving treatment,

Galasinski (2008) argues that their depression cannot be fully understood and effectively treated apart from the centrality of masculinity in their lives and the norms of strength, employment, and their provider status in the family. Related to this line of reasoning is the work of Thomas Joiner (2005), whose model of suicide emphasizes perceived burdensomeness or failed belongingness coupled with the acquired capability for serious self-harm. Though not ignoring psychological factors (mental anguish) or genetic components (serotonin-system genes), Joiner's theory does integrate the importance of how people perceive their social relations (i.e., men's feelings of being a burden to the family or being excluded from employment) or whether they perceive any meaningful social relations at all in their lives (Joiner 2011). Consistent with Joiner's and Galasinski's work, a central issue raised by our analysis of older, generally low-income men is that their views of suicide represent a "complexity of subjectivities and distress" (Ridge, Emslie, and White 2011:152) embodying gender codes of masculinity.

For example, feminist scholars have critiqued the traditional Durkheimian understanding of suicide (Lehmann 1994, 1995) and the sexist and patriarchal assumptions underlying conceptions of women as "natural others," which ignores sex and gender as social constructs in relation to suicide (Range and Leach 1998). Central to our study are the theoretical and empirical advances based on the legacy of R. W. Connell's work on masculinity (Connell and Connell 2005; Emslie et al. 2006; Guttman 2006; Kimmel, Hearn, and Connell 2005). Specifically, Connell's and other scholars' theorizing of masculinity (hegemonic, complicit, resistant, and marginal) is relevant to understanding suicidality in older men given their often conflictive relationship to health, illness, and health systems (Connell 1993; Connell and Messerschmidt 2005; Courtenay 2009; Mac an Ghaill and Haywood 2007). While hegemonic masculinity refers to the "most honored way of being a man" (a normative ideal rarely lived up to that legitimizes men's dominance over women), complicit masculinity is meant to characterize men who benefit from the privileges afforded to them by patriarchal structural arrangements but who do not enact "a strong version of masculine dominance" (Connell and Messerschmidt 2005:832). Resistant and marginal masculinities, in contrast, encompass critical and destabilizing stances toward the dominant masculine ideal. These nonhegemonic enactments of masculinity have been described as "a defense against the perceived threat of humiliation and emasculation in the eyes of other men" (Kimmel 1994:135; also see Hearn and Kimmel 2006).

Rather than assuming that men are "naturally" prone to worse health, risk-taking behavior, and reluctance to seek help, this typology emphasizes the notion that there are not one but many ways in which masculinity is embodied and practiced across space and time (Braswell and Kushner 2012; Creighton and Oliffe 2010; Martin 1998; O'Brien et al. 2005; Wetherell and Edley 1999). Two distinct yet compatible approaches illustrating this are the work of Deborah Cameron (2005) and Mimi Schippers (2002, 2007). Cameron's work centers on the relationship of language and gender, emphasizing the diversity of gender performance and display via discourse whereby social constructs of "masculine" and "feminine" are destabilized and can be enacted selectively by both men and women depending on the context and intentions of participants. Similarly, Schippers (2007:xiii) writes of how through *gender maneuvering* "people manipulate their own gender performance or manipulate the meaning of their own or others' gender performance in order to establish, disrupt, or change the relationship between and among masculinities and femininities." In both cases, binary gender differences are rejected in favor of a diversity of gender identities and practices. In this context, hegemonic masculinity is rendered far more flexible as it is perceived and performed, in the case at hand, by depressed older men.

The implications of this position are significant insofar as it questions traditional biomedical understandings of men's health behavior. For instance, the Health, Illness, Men & Masculinities theoretical model proposes that the concept of masculinity is a fundamental social factor influencing men's health throughout the life course (Bird and Rieker 1999; Courtenay 2009; Evans et al. 2011; Sabo 2005). This conceptual approach to investigating men's mental health has proven fruitful. In particular, scholars have advanced a more nuanced understanding of the social context and social psychological processes involved in men's views and resistance around mental health, specifically mood disorders (Oliffe, Kelly, et al. 2011; Oliffe et al. 2013). One concern that continues to be pursued in this literature is the disjuncture between men's lower rates of depression

and their significantly higher rates of suicide, where depression constitutes an important (though not the only) pathway or strong risk factor for suicidal ideation and behavior (Oliffe, Han, et al. 2011; Scourfield 2005). The masculinity and mental health literature explains this apparent "mismatch" by focusing on men's perceptions of depression as a feminized mental illness from which they seek to distance themselves in order to avoid stigmatization and reduce threats to their sense of masculinity (Oliffe et al. 2012). This in turn leaves them more vulnerable to suicidal ideation and behavior (Cleary 2012).

Compatible with this is the view of suicide as the ultimate act of masculine assertion and heroism (Canetto and Cleary 2012; Kimmel 2004). Spielberg (1993) has argued that this version of heroism embodies men's ability to solve the unique dilemmas of their time. Suicide can be framed as an act of determination and strength, especially in the North American cultural context. In other cultures such as Japan's honor suicide resembles and reclaims an act of masculinity in the context of larger societal obligations (Ikegami 1995). Perhaps this is the "statement" men make by committing suicide; it enables them to enact an autonomous masculine self very much in control of one's fate. This may partly explain why older men who attempt it more often succeed (Canetto 1992). Guns are a commonly chosen method, with the intent to wound vital bodily organs such as the head (Stack and Wasserman 2009; for a related cross-cultural analysis, see Adinkrah 2012). Harwood and Jacoby (2000:284) find that "shooting accounts for over 70% of older suicides." Guns are "hard" and effective, and so a masculine signifier to ensure death (Canetto and Sakinofsky 1998; Marks 1977; Sabo 2005). A futile attempt is experienced as a failure of one's masculinity, a feminine emotional cry for help rather than an "effective" solution to the problem. Successful masculine acts (in general) elicit deference from others in concrete situations; hence these acts are inherently about upholding patriarchy and reproducing gender inequality (Schrock and Schwalbe 2009). Older men's beliefs about suicide indicate that a threatened sense of masculinity plays a particularly salient role in ideation and attempts to end their lives (Stice and Canetto 2008). Oliffe, Han, et al. (2011) have concluded that interactions between masculinity and aging, particularly "cumulative losses" and "inability to fulfill provider roles,"

lead to nihilistic attitudes and susceptibility to self-harm and ultimately suicide.

On the other hand, Oliffe, Han, et al. (2011:449–51) also found that men cited concerns about the impact of suicide on remaining loved ones as primary reasons why their nihilistic attitudes did not translate into suicide. In following up on this aspect of their research, we wish to further explore the specific characterization of masculinity that men evoke and what it means in terms of reinforcing or rejecting hegemonic masculinity. Regarding the older men we interviewed, favoring or rejecting suicide may evoke the same aspects of masculinity but in opposing narrative forms. Further, in rejecting suicide, the nature of men's references to paternity (rather than family in general) raises the question of how they are selectively reconstructing the self in ways that may reinforce hegemonic masculinity.

While the literature has improved our understanding of masculinity as a social component of physical and mental health (Courtenay 2009; Johnson et al. 2012), there is still room for research on how diverse groups of older men understand their emotional troubles and suicide in particular. Though most studies focus on ethnic adolescents, research continues to show that in the United States suicide rates are higher for white men than for either African American or Latino men (Heisel and Duberstein 2005). Most explanations for these differences focus on the role of religion and family as protective factors for these groups (Fortuna et al. 2007), though quantitative studies seldom yield insight into how ethnic subcultures might affect men's subjectivity of their distress and suicide.

Likewise, though some research has found links between social class and suicide (Kreitman, Carstairs, and Duffy 1991; Platt and Hawton 2000; Stack 2000a), we are unaware of any studies that focus on how class intersects with men's conceptions of masculinity, emotional troubles, and suicide. Because our sample is predominantly working class, this is significant (83 percent earned less than $50,000 per year, with 66 percent earning less than $25,000, while only 4 percent had a bachelor's degree or higher). Given the inverse relation between class and suicide (except for a few professional groups such as physicians and dentists) (Stack 2000a), masculinity for working-class men may differ and be more challenged by emotional troubles compared to the men's middle-class counterparts. Further, their

class-based social and cultural resources will certainly affect how they wage their struggle and perhaps how they understand their masculinity and suicide. As Oliffe, Han, et al. (2011) and Oliffe, Kelly, et al. (2011) suggest, the literature on men, masculinity, and mental health/illness continues to emphasize quantitative research that documents the epidemiological landscape of suicide, but it does not closely examine the gendered social and cultural processes informing this act or how people interpret it.

Finally, research on masculinity and mental health has predominantly focused on young and middle-aged men, with little attention to what masculinity means to older men who are coping with emotional troubles, even though this group has the highest rate of suicide. As they age, men are physically less able to even approximate the standards of hegemonic masculinity, and retirement and illness, we argue, confront them as a crisis of manhood as much as aging per se. Our study expands upon these substantive and methodological gaps by considering how the older men's views of suicide are linked to specific components of hegemonic masculinity such as strength, control, and agency and how their narratives of suicide situate spouses, children, and grandchildren in a paternal context.

METHODS AND DATA

This research is based on interview data from the Men's Health and Aging Study (MeHAS, 2008–2011), a mixed-method, cross-sectional study of barriers and facilitators of depression care in older men, which recruited WNH and Latino men over the age of 60 from primary care clinics at a safety-net hospital in California's central valley. MeHAS was approved by the institutional review boards at all participating institutions. Men were asked at the time of their clinic visits if they were interested in participating in a study of depression in older men. If they agreed, they were screened to determine whether they met study criteria (i.e., having depression symptoms, taking depression medication, or being diagnosed with depression). Men were screened for clinical depression (i.e., either major depressive disorder or dysthymia) and prior depression treatment using a two-step process. First, men were administered a modified version of the Patient Health Questionnaire–Revised and a question about past-year depression care use (i.e., "In the past 12 months, have you had any treatment such as medications or counseling for stress, depression, or problems with sleep, appetite, or energy?"). Second, men who screened positive on the Patient Health Questionnaire–Revised or past-year depression care on these screening instruments were further assessed for clinical depression (either major depression of dysthymia) with the Structured Clinical Interview if the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (American Psychiatric Association 1994), and prior depression treatment using previously validated instruments. Each man who met study criteria was asked to participate in an individual, in-depth, semistructured interview at a different time and location of his preference. Informed consent was obtained twice; at the time of the initial screening for study criteria and at the time of the in-depth individual interview. Each participant was compensated $100. Additional MeHAS methods have been described in detail elsewhere (Apesoa-Varano, Barker, and Hinton 2015).

Data Collection

Of 80 interviews with older men in their homes or in the clinic, 77 were conducted by a sociologist (first author) and 3 by a geriatric psychiatrist (study principal investigator). All interviews of Latino men (either in English or Spanish) were conducted by the first author. Interviews ranged from 1.5 to 2.5 hours, were conducted in Spanish or English per participant preference, and followed a semistructured interview guide, with extensive use of probe questions, covering sociodemographic background, depression experience, family response to men's depression, suicide, depression help seeking, and treatment in primary care. For this analysis we focused on men's responses to questions and probes related to the high rate of suicide in older men and what they thought might be done to help these men, their own experiences or those of other men with attempted suicide and suicidal ideation, and their views of what keeps older men from killing themselves. All interviews were transcribed verbatim; those in Spanish were first transcribed verbatim by bilingual research staff and then translated into English. Bilingual co-investigators reviewed transcripts and translations for completeness, accuracy, and quality. While 80 interviews were completed, only 77 (47 WNH, 30 Latino) were

Table 1. Sociodemographic Characteristics of Interview Participants

Characteristic	N (%)
Sex	
Male	77 (100)
Age	
60–64	39 (51)
>64	38 (49)
Race/ethnicity	
Non-Hispanic white	47 (61)
Latino	30 (39)
Education	
None	3 (4)
Grades 1–6	11 (14)
Grades 7–11	15 (20)
Grade 12 or GED	21 (27)
College 1–3 years	15 (20)
College 4 years or more	8 (10)
Graduate degree	4 (5)
Marital status	
Married	46 (60)
Divorced, separated, widowed, or cohabitating	31 (40)
Self-reported health	
Good to excellent	27 (35)
Fair	30 (39)
Poor	20 (26)
Language of interview	
English	60 (78)
Spanish	17 (22)
Clinical depression	
Past year clinical depression	60 (78)
No past year clinical depression	17 (22)
Clinical depression treatments	
Past year depression treatment	46 (60)
No past year depression treatment	31 (40)
Employment	
Retired	63 (82)
Unemployed but seeking work	3 (4)
Employed part-/full-time	11 (14)
Income	
<$10,000	22 (28)
$10,000–$25,000	29 (38)
$26,000–$50,000	13 (17)
$51,000–$75,000	3 (4)
$76,000–$100,000	6 (8)
>$100,000	3 (4)
No answer	1 (1)

usable for qualitative analysis (3 were lost to technical issues). For sample sociodemographic characteristics, see Table 1.

Data Analysis

Data analysis followed a grounded, social constructionist approach to identify main analytical categories and their relationships (Charmaz 2008; Charmaz and Belgrave 2012; Strauss and Corbin 1998). In an initial open-coding phase, the research team collectively read interviews and achieved consensus regarding major topical categories that included psychosocial distress, family, aging, substance use/abuse, suicide, masculinity, coping/self-management, and formal help seeking. These topical categories comprised a formal code book with definitions and examples used throughout the analysis to ensure consistency. The three researchers involved in this study then independently and systematically recoded all 77 interviews for these eight major topical categories. During this stage, the researchers coded the same interviews and then compared their coding in ongoing meetings to compare their coding and interpretation. The team followed this procedure until all interviews were fully coded independently, were discussed collectively, and corrections were made based on consensus. Once this first "chunking" was completed, the lead author conducted further analyses of interviews with a focus on the material coded under the topical category of suicide to identify subthemes (e.g., what leads men to attempt suicide, what stops them from killing themselves) and the patterns regarding how men described their views of suicide. These subthemes were also integrated into the code book, and all coding was checked by the researchers using the agreed-upon code book. While the lead author completed the refined/deep-level coding of all interviews, the other researchers systematically coded every fifth interview for the purpose of comparing and cross-checking the consistency of the coding. If discrepancies were identified, then the researchers reviewed the material in a collective manner to resolve them. The findings presented below are the outcome of an extended iterative interpretative process in which the researchers regularly discussed the results of this refined coding of the suicide theme and evaluated and resolved discrepancies between team members through a consensus-building process that involved reviewing transcripts as a team, checking discrepancies against the code book, and recoding if needed. NVivo 9.0 qualitative software was used throughout the analysis process for ease of data management,

open and refined coding, and cross-checking and comparing coding across researchers.

WHEN SUICIDE BECOMES A POSSIBILITY

The Loss of Economic Means, Relationships, and Physical Ability

Though a difficult topic, older men did not shy away from discussing suicide, either spontaneously or when prompted. Indeed, many men spoke almost as if it were a reasonable and/or inevitable consideration. "If you were like me" said one 72-year-old WNH man in a wheelchair who could barely make ends meet receiving social security and some disability insurance, "who wouldn't think of suicide?" Men's views of suicide and the emotional troubles that shadowed their lives pointed to the confluence of three specific losses, what Oliffe, Han, et al. (2011:448) term "cumulative loss": viable economic means, deteriorating kin relationships, and physical decline. Taking a deep breath and pausing for a moment to think, one 63-year-old WNH man reflected on his own situation:

> Oh, money right now because it is kind of tight. We are a little far in debt, but it is coming, you know, slowly but surely coming out of it. Then I am worried about my wife . . . her health isn't good and [she] don't listen to me . . . we argue all the time. . . . My health [is] not good anymore. . . . I just got depressed and . . . and I think about it [suicide].

This man's "worry" is triggered by economic struggles, his wife's health, his health, and marital discord. In people's lives these issues are, of course, interconnected in complex and uncertain ways to the state of worry that leads to suicidal thoughts. Similar to others we interviewed, a 64-year-old Latino man spoke of the confluence of monetary, physical, and social loss:

> The truth is that, many times you try [attempt suicide] because one no longer has the love of a wife, the love of children . . . so the lack of love makes one make mistakes. Many times because one is in pain one says I would rather stop feeling in order to stop suffering from the physical pain, right? But what motivates one the most is . . . if one does not have, does not have the love of a son, does not have the love of a wife because she has passed [or] you always have problems with them, one wonders "what am I doing here? I don't have people's understanding; I don't have anything, absolutely nothing. I don't have money, I can't meet their [family's] expectations and this and that," and that is what makes one commit suicide.

Though distancing himself from the topic of suicidal ideation by using the third person ("one makes mistakes"), this man highlighted the losses that framed the worldviews of most men we interviewed. One WNH man (age 69) spoke softly as he grimaced: "The fact of you sitting in pain, I know that in my case, I see [pain as making me] think of suicide, wanting to [end life]. Like I feel now also, I've [been] married to my wife, so I should be with her [deceased]." Similarly, a 61-year-old Latino man confided, "my body is wearing down. I'm getting slower. I can't do what people are expecting me to do, I can't do that no more." Physical pain combined with ongoing economic constraints and conflictive or lost social relationships left these men emotionally exhausted at best.

Consistent with the findings of Oliffe, Han, et al. (2011), men's reasoning around suicidal ideas and/or acts revolved around their roles as patriarchs of a nuclear family and productive, earning workers. The overwhelming majority of these men were from working-class backgrounds and had been employed in low-skill and manual labor throughout their lives (e.g., truck driving, construction, farming, and janitorial work). As their roles in the public and private spheres began to recede, the wound of losing their breadwinner status was aggravated by their salty perceptions of disrespect and dismissiveness by family and friends. With 86 percent of our sample out of work (63 retired and 3 unemployed and looking for work) they felt stranded without a central tenet of masculinity. As Galasinski (2008:148) documents of men with depression, even if their illness precludes it, the "work imperative" continues to stalk them because it characterizes "normal" (read: masculine) men. Retirement likewise undermines the work imperative of masculinity, and the men's perception of uselessness was compounded

by a strong sense of having become physically weak and feeble. Being unemployed and physically frail emotionally underscored one of their most strongly held masculine tenets: "men are strong." This fear of weakness, or what might be a corollary to Joiner's (2005) "perceived burdensomeness," was central to how they understood becoming older impaired men. In their eyes, a vibrant and vigorous self had deserted them, and they saw few alternative codes of masculinity they could substitute. Specifically, compared to middle-class men for whom physicality might not have defined their masculinity as much as, say, cultural activities and interests, working-class men may have found themselves with fewer opportunities to display their gender in a manner reminiscent of their past.

Again, distancing himself from the topic by using the third person, one 65-year-old Latino man put it this way:

> But they [older men] do need to be understood, not for others [relatives] to argue with them [older men], to contradict them. Instead to let them know that they are mistaken, but to know how to do it instead of saying "you don't know, don't talk" because that makes one angry, it makes one feel useless, that one does not know how to do things.

Older men found proof of this illegitimate masculinity in what they perceived as others' dismissal, disregard, or mistreatment of them—they no longer mattered, they were no longer in the driver's seat. This shifting position from center to periphery in their intimate social world (Connell and Messerschmidt 2005) made men feel invisible, no longer seen or heard, which reflects what Joiner (2005) terms "failed belongingness." Now that he was not working and at home, one 71-year-old WNH man described it in these words:

> And also when the family ignores you. They tell you "shut up, you don't know!" Well, I used to know, tell me that I am wrong now, but [people] tell you "shut up, you don't know, don't talk." That happens to me with my wife, "don't talk, shut up," and why can't I talk? I have a mouth, I think, I see, I am deaf, but so what? Tell me, explain to me and so many times

because we have those arguments, I'd rather leave the house because I don't think I am a person that reacts well. To be ignored is the worse . . . and that to me is like they are ignoring me . . . I don't exist anymore.

For this man, it is not just the self that does not exist anymore; it is *the man* that no longer exists. Given their "invisibility," men engaged in a solitary struggle against despair. "They can't see other solutions to their problems" said one Latino man (age 72) after describing his own suffering. "[It's] too much pressure in their [older men's] mind." Again, as if purveying the scandal afflicting our participants, one 68-year-old WNH man stated,

> [Older men commit suicide] because their whole world was taken away from them. They [older men] look on their damned life. Everything you fought for in yourself, all the pride and the love, and the respect. All things that mean something to you. . . . They [older men have] lost everything because they were replaced, okay? So they lost all that money, and all that, everything they fought for. When you take everything away from a guy, they can take it away and you just don't care, huh? They treat [you like] nothing.

For these working-class men, constructing a self pivots on questions of strength and agency. Suicide was fundamentally linked to masculine attributes of strength insofar as the only thing worse than being a shamed man was being a weak shamed man. Similarly, men's suicide accounts emphasized their inability to alter the trajectory of their lives. How can one act in the world when "your whole world is taken away," when some larger force imposes itself upon you and you cannot resist? They had faced challenging situations in the past, but things are different now. In this context, suicide becomes something about which they have a choice and can act. That is, a choice that could end the physical and emotional pain and, equally important, a choice that allows for a decisive final act of selfhood; *a statement of one's masculinity.* As Emslie et al. (2006:2252) found, the option of suicide gave some men a sense of control. But as our men spoke about suicide we began to see parallel narratives

that placed "strength and choice" on opposite sides of this most ultimate act: the strength to take or preserve one's life.

A Man Calls the Last Shot: "I Get to Say How It Goes!"

Though a highly stigmatized act, suicide for some men was seen nonetheless an opportunity to transcend their perceptions of weakness by reclaiming the "I am strong" tenet. In perhaps one of the most poignant narratives we heard, a 64-year-old WNH man recounted his brush with suicide:

So I decided I was going to do that [kill myself]. I was sitting at my desk in my office at my shop, and put it [gun] in my mouth. Cocked it, and somebody walked in the door. It was a friend that's in a depressive state now. And he catches me with this gun in my mouth. He said, "what the fuck are you doing?" I didn't want to feel the pain anymore, the pain of loss. It was my way to say what needed to happen, I get to say how it goes!

Some men reasoned that suicide sent the message that a "man is in charge of his destiny," still able to undertake action with a successful (in their mind) outcome. This provided them a symbolic framework to reclaim a legitimate masculine status. Recalling an incident when an uncle in the family attempted suicide, a 68-year-old Latino man said,

I have always said that the reason . . . [older men] don't commit suicide is because they're afraid. [They] aren't strong enough to do it! One of my wife's uncles tried to commit suicide. He shot himself in the stomach, ah! I told my wife, "If he had really wanted to commit suicide he should have [gone] . . . for the head, he was reaching out for help." . . . They [older men] are the biggest cry-babies, they are the biggest complainers.

As the above quote illustrates, references to "reaching out for help," "the biggest cry-babies," and "complainers" are the feminine antithesis of hegemonic masculinity, which emphasizes independence and stoicism. Older men who

successfully commit suicide are strong and decisive, taking charge and doing it by means that would with certainty end their lives. "Ending it all" allowed them to make a final assertion of masculine selfhood. Another Latino man (age 62) emphatically said,

I would get to the point where I would say "okay, that's it. Just both of us just finish things off." I mean, like I told the guys, if I want to commit suicide, all I got to do is walk out here in the street with a gun, fire about 2 or 3 shots, man, and there would be about 50 shots fired at me. And, that's it. *I get to say when it end[s].* (emphasis added)

These men spoke of taking charge and wanting to "resolve" their situation by "cutting one's losses." This particular discourse of masculinity provides the cultural context of the epidemiological finding that suicide is more likely among older men than any other group in the United States. It may also be indicative of a working-class version of masculinity whereby the choice to resolve one's suffering is at hand, contrary to a life of fewer options than that of their middle-class counterparts.

There is yet another level at which suicide and masculinity intersect in these narratives, and that is that men have contemplated it over time. They are trying to make sense of their lives as they reason about committing suicide. In other words, suicide becomes *a decision to be made* rather than an impulse that propels one (Joiner 2005:184–88). Even though, as Austin, Mitchell, and Goodwin (2001) note, depression involves a degree of cognitive impairment, masculinity remains a potent symbolic framework for elderly men. And "reasoning through," "deciding what to do," and weighing possibilities is consistent with codes of masculinity that call for men to be nonemotional, rational actors. After all, emotionally charged impulse signifies the feminine, which may be even more threatening to working-class men's conception of their masculinity. Older men's views of suicide must thus be understood in the context of hegemonic masculinity both in the sense of "strong, in-charge men" but also "detached, objective, rational thinkers." But if suicide appears as a last gasp for some men, for others it signifies the complete opposite. In this context of strength and choice, a strong man chooses to stay alive.

The Choice to Live: "Men Don't Quit!"

While some men spoke of suicide as a reasoned choice made by strong men, for other men it represented defeat, *the act of a weak man who is no longer in control*—the very thing they are struggling to overcome. The narratives of a majority of older men in our study hold that suicide is a cowardly act and that strong men stick it out and fight through the pain of aging and loss. Rather than fleeing from pain, in this narrative, men face pain boldly in a manner that is consistent with hegemonic masculinity. One 71-year-old WNH man passionately explained why in the end he would not commit suicide:

> You can't give up! Being a man don't make giving up part of the equation! If you give up, you might as well just throw in the towel. Go ahead, commit suicide. Nobody would give a shit! Because that's the way life is. If you are not willing to meet life head on. . . .

Similar to those who spoke favorably about suicide, men who viewed suicide as a nonmanly act held to a masculine self that is characterized by fearlessness, decisiveness, and the strength to deal with physical and emotional pain. As one WNH man (age 69) saw it,

> They [older men who consider or attempt suicide] are cowards; they are cowards because they are not facing the problem. You have to face the problem and if you can't, you need to ask for help, but I am not going to kill myself because of that, that is cowardice.

Likewise, some men who rejected suicide as a remedy for waning masculinity favored taking medications as preferable to being perceived as a failed man. A WNH man (age 72) said,

> They [older men] are high, or drunk, I don't know, but a man who is in his five senses doesn't kill himself because they have problems, they have health problems, or any type of problem. . . . Drugs are not good. . . . But not me, I am taking drugs [prescribed antidepressants], but it's the minimum, that's what the doctors say, "you

are on the lowest dosage" to keep me away from [suicide].

The notion that suicide signifies a lack of valor and strength was so compelling that some men said it was acceptable to ask for help or use medications "if that's what it takes." Ironically, men with depression typically consider both asking for help and taking medications for one's emotions as "womanly" (Addis 2008; Courtenay 2000; Oliffe, Han, et al. 2011). However, in light of being considered a coward, calling for help or taking medications appeared to some (especially working-class) older men the lesser of two evils. And as Emslie et al. (2006:2252) document, rather than resembling a feminized condition, help seeking and using (even "the minimum") medications in this context are consistent with the masculine code of regaining control.

Contrary to those who masculinized suicide, this narrative emphasized men's concerns about their families. In particular, they spoke of themselves as nested in their families and an intergenerational chain of cohesion and healing rather than dominance. When suicide was conceived as a cowardly act, it was incompatible with how men wanted others to view them. But what was interesting about these men's concerns about others was how frequently they spoke of *children.* Expressing concern about what his family would think, a 61-year-old Latino man told us,

> It's a cowardly act that just hurts others. You know why, I have a rifle, if I do that [commit suicide] I will harm my children and what are they going to say? "My father was such a coward that he took his own life." Why, to leave them, I would rather not [have] them say that [about] me. One has to think about the kids first. There are some that don't care about their kids or father and mother, I think that's [suicide] stupid.

Similarly, another 67-year-old Latino man referred to his children as he spoke of rejecting suicide: "Sure, because if they [men] get the idea to kill themselves, that is not good. I want to think of my kids first because they would say, "why did he kill himself, such a coward." Why would I do such a thing? I won't do it." Or as one WNH 65-year-old man told us,

This [idea of] better to be dead than to be a burden. . . . If one pays too much attention to that it makes you miserable. . . . Think of the children and, my sons. . . . I have my gun but I think to myself if [I am a] man . . . one is a [man] and can't do that [suicide].

In the context of gender and suicidal ideation, do these older men find meaning in fathering and grandfathering as manly acts? By emphasizing the importance of children in rejecting suicide, are the men here excavating a repressed aspect of hegemonic masculinity or integrating facets of a feminine self into their identity as men? If the latter, one might expect to see more expressions of a caring ethos beyond being an economic provider that extend to wives as well as children, for hegemonic femininity does not hold that one cares only for children but not spouses (Schippers 2007). Besides being strong for their families, such men might also address their vulnerabilities and find satisfaction in what traditionally has been considered women's roles such as caretaking of children, teaching the young, and performing domestic chores; perhaps a "mellowing" that allows them to embrace a more nurturing self (Gutmann 1994). Indeed, our interviews do show signs of a caring ethos of shared responsibilities. As a one WNH man (age 70) candidly put it,

So, okay, a [older man] that wants to kill himself, if they have made up their mind, it's pretty hard to change. But the way is to create change by doing little things. I never [before] would have been as open as I am today. It's by being able to express your feelings on a feeling level, and not being ashamed of your feelings.

Or as one 71-year-old Latino man explained, rediscovering a caring fathering self was a way of resisting suicidal ideation:

If she [wife] says, "let's eat," we [men] should help her prepare food, wash the dishes, help her around the house. He [older man] does not lose his masculinity for doing that. On the contrary, in my opinion, that is good because one eats, talks, watches the kids while one is at home and I think that the man should have 100 percent of the responsibility, to support the kids, to

help the mother bring them up, to not let them be on the streets. Make sure they do their homework, take them to school and all and well that is one's responsibility as a father or grandfather. I didn't see that before but now I do it . . . that keeps you away from thinking about it [suicide].

For one WNH man (age 72) sharing in domesticity was important to his sense of masculinity and avoiding thoughts of suicide:

So, plan new responsibilities. I think this has made me better. . . . "Honey, I'm going to wash the dishes. Honey, I'm going to set up the table. Honey, I'm going to cook tonight, you go and relax." That now makes me [feel] like a man. . . . It keeps me out of trouble [thinking of suicide], you know. . . . But it is the sharing of the community or family.

But though these men certainly expanded the masculine self to include more characteristics typically associated with hegemonic femininity (Schippers 2007), they were a notable minority in our sample. To the extent that strong men chose to reject suicide and bravely face their situation, it was for their children and grandchildren—not their wives. One 65-year-old WNH man summed up the sentiments of the vast majority of older men whose opposition to suicide emphasized the fatherhood aspect of masculinity:

I think I can tell what makes me happy, what makes me feel good now. I have a grandson. When he's around, when I get to take care of him, I have nothing but thoughts of joy, and doing for him, and it's very easy. It makes me realize what I missed out on with my kids. With them [my children], I didn't do for them because I didn't have thoughts of being that way. I [thought] "their mom is there to take care of them. I'm making the money." And, I never interacted. I think for older men, if they got something like that, that's going to make them feel like they are needed, if they can accept that. I think they aren't [going] to think suicide.

In sum, for most men the idea of suicide as "quitting" or cowardly was as untenable as being a "fallen" man. Suicide violated their masculine

values of strength and choice but also their esteem, if not responsibility, as fathers and grandfathers. Indeed, we must note here how these narratives emphasize the men's reputation as much as any sincere concern for being a caregiving father. To the degree that men spoke of "what are they going to say? 'My father was such a coward that he took his own life,'" they are emphasizing fatherhood as a marker of their personal masculine status. In this context, fatherhood rather than being a husband may resonate more with a working-class parental division of labor in which these men considered themselves the breadwinners and not the bakers. Though these narratives opposing suicide allude to feminine dimensions of self in older age, we feel the overwhelming symbolic weight of their discourse rests upon a sense of self that, while caring, is still ensconced in hegemonic masculinity and patriarchy.

DISCUSSION

How our group of older Latino and WNH men spoke about suicide raises important issues that are relevant to understanding masculinity and mental health for elderly men. Two particular concerns stand out: (1) How do the notions of strength and caring inform their suicidal ideation, and (2) How do ethnicity and class intersect in how men discussed suicide?

The Strong and Caring Man

The centrality of strength in men's narratives cannot be understated, especially given the common assumption that this core element of hegemonic masculinity has exclusively negative consequences associated with violence. But the strength tenet associated with masculinity may also function contrary to such assumptions and should not be considered solely as self- (or other-) destructive (Collier 1998). For our older men, being a strong man worked both to justify and to reject suicide; hence the ideal of strength can be considered a *sliding signifier* of masculinity. Still, as men spoke of being strong in resisting suicide they were reinforcing hegemonic masculinity in terms of not being cowardly and stoically facing physical and emotional pain. As Connell and Messerschmidt (2005:840) remind us,

> Most accounts of hegemonic masculinity do include such "positive" actions such as

bringing home a wage, sustaining a sexual relationship, and being a father. Indeed it is difficult to see how the concept of hegemony would be relevant if the only characteristics of the dominant group were violence, aggression, and self-centeredness. Such characteristics may mean domination but hardly would constitute hegemony—an idea that embeds certain notions of consent and participation by the subaltern groups.

Hegemonic masculinity must be understood as operating within a field of salient social relationships within institutional settings through which meaning is reconstructed in relation to the trajectory of biography, self, and society. For example, the idea of strength can be relevant to the depression experience of women, not only men, depending on the context and ethnic group being considered. As Beauboeuf-Lafontant (2007) argues, a "discourse of strength" stereotypes Black women whereby they mask their depression experiences. Insofar as this discourse is internalized it hinders their ability to express their distress while undermining their treatment and recovery. Similarly, for the Latino men in our study strength may be associated with stereotypes of machismo, or it may be characteristic of what Lu and Wong (2014) identify as culturally distinct variants and/or rejections of hegemonic masculinity that Latinos enact based on their subordinate status in the United States (see also Rivera-Ramos and Buki 2011). For the participants in Lu and Wong's study (average age of 25) strength might refer to "performing toughness," which emphasizes restricting emotions and resilience. For other men strength was understood in terms of "enacting el hombre," which referred to being a dignified achiever and provider in protecting one's family. However, whether responding to hegemonic stereotypes of machismo or enacting culturally distinct and/or nonhegemonic variants, Lu and Wong argue that the inability to live up to either ideal caused notable stress in their participants. Given the advanced age of our sample, their stress appears to be magnified, even among those men who cared about their descendants.

Indeed, a significant finding of our interviews was the references to paternal caring among older men who rejected suicide, thus upholding a gentler side of masculinity. But as we asked above, how much of this caring self signals a reclaimed masculinity or an expressed feminine self? Though

the mental health literature notes how men's perceptions of depression as a feminized mental illness lead them to disassociate from this condition because of stigmatizing threats to their masculine identity (Oliffe et al. 2012), our findings confirm other research (Emslie et al. 2006) that finds men manipulating masculine gender codes in ways that allow them to voice their emotional suffering, seek help, and utilize medications. Theoretically, this is important insofar as it speaks to the boundaries of gender codes in the construction of self (Epstein 1988). Our findings highlight the flexibility of these boundaries for how older men negotiate aging and emotional troubles but also their elasticity in keeping hegemonic masculinity intact. That the men we interviewed were older cast them at the twilight of their idealized masculinity, and their remove from work left them fewer institutional opportunities to enact conventional masculine codes. Consequently, traits commonly considered feminine might become more salient to their sense of self and daily lives, as we saw in the views of men who spoke of helping their wives or engaging in domestic chores. But as we also argued, this was a minority view, and it was *children, not wives*, who appeared most often in the narratives of men who rejected suicide.

The issue of fatherhood and children has been addressed in the context of hegemonic masculinity (Donaldson 1993) mostly in terms of the gendered division of labor and how men fail to become intimately involved with their children or grandchildren. Yet some research has documented examples of men who exemplify child care in ways conventionally seen in women and who resist the hegemonic call to be distant from their offspring (Brandth and Kvande 1998). Our interview data are mixed in this regard when one considers *how* children mediate between the men and suicidal ideation. For some men, concerns about children and grandchildren had more to do with not wanting their (masculine) reputations tarnished, while for others there appeared to be authentic expressions of desiring intimacy with them. All in all, children and grandchildren helped men reconstruct a sense of being productive—family maintenance—given their disengagement in breadwinning activities in the public sphere, and this may be important in diagnosing and treating depression (Kilmartin 2005). For the Latino men in our study, this version of masculinity may correspond closely to what Lu and Wong (2014) refer to as "enacting el hombre." Nonetheless, caring

sentiments among elderly men in general should not be seen as *a sufficient condition* for rejecting suicide, as such feelings of familial responsibilities may mean to some men that their families "would be better off without them" (Emslie et al. 2006:2253). Still, if bending or reinforcing gender codes keeps men from committing suicide, then many families and health care practitioners alike might find here a viable therapeutic option. In other words, helping depressed elderly men redefine their masculinity in relation to their children and grandchildren (and ideally wives) may keep suicidal thinking at bay and support families along with his mental health (Emslie et al. 2006). This may not be so easy, however, as a few important studies of depressed fathers remind us (Galasinski 2013; Reupert and Maybery 2009).

On Ethnicity and Class

Our findings do not indicate any significant distinction between Latino men and WNH men in terms of how they reasoned about suicide. On the one hand, for both groups masculinity was far more pronounced than ethnicity, and their narratives were not notably inflected with ethnic subtleties or nuance. Nor were there clear ethnic differences in how these men spoke about fatherhood and child care as reasons for rejecting suicide. The absence of any cultural valence in itself, however, is not reason to discount the importance of ethnicity. While ethnicity is still culturally salient for the Latino men, we argue that in the U.S. context it operates *similarly* to WNH men's reinforcing their understanding of masculinity and strength and thus remains silent in their narratives of depression and suicide. Likewise, where fatherhood and family may be central to Latino versions of masculinity (e.g., enacting el hombre), these too may be reinforced though not necessarily altered for our older men by their stance on suicide. For instance, in Rivera-Ramos and Buki's (2011) study of prostate cancer screenings among Latino men in the United States they found that while their middle-class participants identified more closely with *caballerismo* (what Lu and Wong 2014 refer to as enacting el hombre) and their working-class participants variously identified with both *caballerismo* and machismo, all men strongly resisted prostate cancer screenings via digital rectal examinations as an affront to their manliness.

Regardless of which ethnic version of masculinity holds sway, aging men with depression feel it slipping from their grasp, and suicidal ideation restores it (at least) symbolically. Still we must emphasize that these distinctions in the meaning of masculinity for either Latino or WNH men may be critically important in terms of diagnosis and treatment. Insofar as older men construct their masculinity in line with a gentler paternal emphasis they may be more effectively counseled toward familial activities, therapy, medication, or reestablishing social relationships in their communities.

On the other hand, social class may be more relevant for how these men view masculinity and suicide in two ways: (1) employment and (2) social and cultural capital. Because we categorize the vast majority of our sample as working class based on occupational histories, educational levels, and income, a key to these men's masculinity was their reliance on the physicality of working-class jobs to validate a masculine self. As our interviews indicate, however, given the impediments of aging, their faster or definitive "aging out" of these jobs (in terms of physical disability due to injury, no access to health care, or poorly treated conditions) compared to men in middle-class occupations poses a direct affront to a masculine self (though see Lewis and Sloggett 1998). Contrary to older men with more education and perhaps professional occupations, working-class men may find their masculine self "on the ropes" the further they age away from the labor force and the employment role sets through which self is constructed. This is likely harder on working-class men, for whom the dichotomy of work and family falls heavily upon their provider role, thus making their transition to fathering in the domestic sphere more challenging.

Similarly, older working-class men with less education and nonprofessional occupations may find fewer social outlets (such as leisure pursuits or membership in voluntary associations) for expressing their masculinity that do not rely on paid labor for validation (Bowling 2005). By virtue of their educational and occupational background, older working-class men may have accrued social capital that supports different friendship networks and help seeking but also cultural capital that provides different symbolic resources for dealing with retirement and embracing paternity. In other words, working-class older men may enjoy supportive relationships that help

them work through depressive episodes over time. As our interviews suggest, alternative reconstructions of masculinity do not require that men abandon the gender codes they have enacted all their lives, while an emphasis on paternal caring and familial responsibilities may be a pathway to less suffering and aging with dignity.

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