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"I'm Not Afraid of Dying Because I've Got Nothing to Lose": Young Men in South Africa Talk About Nonfatal Suicidal Behavior

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Abstract

First-person narratives of suicidal behavior may provide novel insights into how individuals with lived experience of suicide understand and narrate their behavior. Our aim was to explore the narratives of young men hospitalized following nonfatal suicidal behavior (NFSB), in order to understand how young suicidal men construct and understand their actions. Data were collected via narrative interviews with 14 men (aged 18–34 years) admitted to hospital following an act of NFSB in Cape Town, South Africa. Narrative analysis was used to analyze the data. Two dominant narratives emerged in which participants drew on tropes of the "great escape" and "heroic resistance," performing elements of hegemonic masculinity in the way they narrated their experiences. Participants position themselves as rational heroic agents and present their suicidal behavior as goal-directed action to solve problems, assert control, and enact resistance. This dominant narrative is incongruent with the mainstream biomedical account of suicide as a symptom of psychopathology. The young men also articulated two counter-narratives, in which they deny responsibility for their actions and position themselves as defeated, overpowered, wary, and unheroic. The findings lend support to the idea that there is not only one narrative of young men's suicide, and that competing and contradictory narratives can be found even within a dominant hyper-masculine account of suicidal behavior. Gender-sensitive suicide prevention strategies should not assume that all men share a common understanding of suicide. Suicide can be enacted as both a performance of masculinity and as a resistance to hegemonic gender roles.

Keywords

first-person narratives, nonfatal suicidal behavior, South Africa, suicide attempt, masculinity, gender roles, suicide prevention

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Suicidal behavior is a global public health problem, with suicide ranking as the second leading cause of death among young people (15–34 year olds) and accounting for approximately 800,000 deaths annually (World Health Organization, 2014). For every completed suicide, there are an estimated 20–30 episodes of nonfatal suicidal behavior (NFSB; that is, deliberate self-harm with non-zero intent to die; Wasserman, 2016). NFSB is a strong predictor of future suicidal behavior and understanding its etiology is integral to suicide prevention (Hargus et al., 2009; Zahl & Hawton, 2004). Epidemiological studies have focused on identifying risk factors associated with suicidal behavior (Brock et al., 2006; Franklin et al., 2017), but there is a comparative dearth of research exploring first-person narratives of suicide (Bantjes & Swartz, 2019). It is within this context that we explored the narratives of a group of young men admitted to hospital following an act of NFSB in South Africa (SA). We

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were interested in documenting how young men narrate their experience and what this might reveal about how they construct and understand their suicidality. We focused on young men, given the evidence that patterns of suicidal behavior are gendered, with NFSB typically more common among women and completed suicide more common among men (Canetto & Sakinofsky, 1998; Hawton et al., 2007). In SA, men are four times more likely than women to die by suicide (Bantjes & Kagee, 2013), and in one study of NFSB men accounted for 40.5% of NFSB patients seeking treatment in the emergency room of an urban SA hospital (Bantjes, Breet, et al., 2017). Understandings of suicide have changed over time, and the phenomenon has been constructed and narrated in various ways at different times and places (Hecht, 2013).

The contemporary dominant biomedical view of suicide frames suicidal behavior as a symptom of mental illness and positions suicidal individuals as irrational and in need of psychiatric care (White et al., 2015). Studies conducted within this biomedical paradigm have consistently reported that suicidal behavior is strongly associated with mental illness and that as many as 90% of individuals who die by suicide have a psychiatric disorder (Cavanagh et al., 2003). Indeed, there have been recent moves by the American Psychiatric Association to establish suicidal behavior as a distinct psychiatric disorder within the *Diagnostic and Statistical Manual of Mental Disorders*, thus firmly establishing it as a form of psychopathology (American Psychiatric Association, 2013). The dominance of this biomedical view of suicide is evident in the strategies most commonly used for suicide prevention, which consist of improving clinician's ability to identify at-risk individuals and promoting access to evidence-based mental healthcare (World Health Organization, 2014).

But suicide has not always been positioned as a psychiatric problem or as the irrational action of mentally ill people. In classic Greek and Roman texts, suicide is narrated as heroic, rational, considered, and as an act of defiance (consider, for example, the legend of Lucrecia; Garrison, 1991). In academic social science literature, suicide has been variously constructed as both a psychological and sociological phenomenon (Kral et al., 2017; White et al., 2015), with psychological texts typically framing suicide in terms of intrapsychic processes, internal subjective experiences, and overpowering emotions, while sociological texts have foregrounded the role of socioeconomic context and cultural norms in the etiology of suicide (Nock, 2014). For example, one psychological text described suicidal youth as having a strong and overpowering sense of misery, disgrace, and self-loathing (Everall et al., 2006). By contrast, there are examples of sociological texts that position suicide as a function of economic stressors and interpersonal conflict (Iemmi et al., 2016; Wyder et al., 2009), gender norms (Cleary, 2005), cultural practices (Kral, 2012), social cohesion (Durkheim, 1987), and issues of integration, regulation, and imitation (Wray et al., 2011).

A range of metaphors have been used in academic literature to convey the phenomenology of suicide. Gilbert and Allan (1998) used the metaphor of "arrested flight" to describe how suicidal impulses arise from feeling trapped in a hopeless situation with no perceived chance of rescue (Gilbert & Allan, 1998). Similarly, suicide has been described as an "escape from self" (Baumeister, 1990), and as a "cry of pain" (Pollock & Williams, 2001; Williams, 2001). Notably, many of these metaphors place the individual and their inner subjective world at the center of the account of suicidal behavior, which is in stark contrast to some contemporary writings within the field of "critical sucidology" that construct suicide as an emergent cultural phenomena (White et al., 2015). The cultural turn in suicidology has shifted the focus onto the cultural context in which suicidal behavior is performed and the situated meanings this behavior holds (Bantjes & Swartz, 2017).

Cultural explanations for high rates of suicide observed among mem, characteristically attribute suicidality to cultural norms and gender roles (Southworth, 2016; Stack & Wasserman, 2009), using metaphors like "toxic masculinity" (de Boise, 2019) and drawing on the construct of "hegemonic masculinity" (Connell & Messerschmidt, 2005) to link men's suicidal behavior to the "masculinity in crises" discourse (Jordan & Chandler, 2019). Scourfield (2005) has proposed the concept of "suicidal masculinities" to illustrate how men's suicidal behavior can be read as a product of socially sanctioned gender dynamics entailing power, control, resistance, and subordination (Scourfield, 2005). There are examples of contemporary texts from various countries framing male suicide as a cultural product of masculine identities and gender roles, including texts from Australia (River, 2014), Europe (Cleary, 2012), Ghana (Adinkrah, 2012), and SA (Bantjes et al., 2017; Niehaus, 2012). Writing in this genre typically draws directly or indirectly on role theory and explains men's vulnerability to suicide as a function of gender norms, societal expectations, and men's inability to perform prescribed masculine identities within structured dynamic power relations (Canetto & Cleary, 2012; Carrigan et al., 1985; Möller-Leimkühler, 2003). Cultural accounts of men's suicide tend to be written from a constructionist perspective, which understands gender as relational and performative (Butler et al., 2004). Canetto and Cleary (2012) have noted that many studies on gender and suicide are problematic because they tend to treat male and female behaviors binary opposites and conceptualize men as a unitary group (Canetto & Cleary, 2012),

resulting in simplistic and reductionist conclusions, such as ascribing male suicides to rationality and strength and female suicides to emotionality, weakness, and a "cry for help" (Chandler, 2019). Within this binary completed suicides are seen as tragically heroic and masculine, while attempted suicides are associated with emotionality, weakness, and femininity (Jaworski, 2010a). Grouping all men together and seeing all male behaviors the same obscures the existence of multiple masculinities and denies that performances of gender are contextual and intersectional. Institutional structures, cultural norms, economic circumstances, social status, age, and race all shape performances of gender (Canetto, 1991)—giving rise to plural, dynamic, hierarchically arranged, and sometimes contradictory and contested masculinities. Although it is understood that there are multiple masculinities, Connell has theorized the concept of hegemonic masculinity to denote the dominant and valued patterns of masculine practice that structure and legitimize a hierarchy of relations among men (Connell & Messerschmidt, 2005). Originally hegemonic masculinity was understood to be enacted through performances of strength, power, rationality, oppression, and patriarchy (Connell, 2013), but the concept was subsequently expanded to acknowledge how dominant modes of masculinity are dynamic hierarchies shaped by subordinated masculinities, resistance, geography, and the agency of women (Connell & Messerschmidt, 2005). Although much contested (Carrigan et al., 1985; Chandler, 2019), the concept of hegemonic masculinity has been used to further sociological analysis of men's suicidal behavior (Abrutyn & Mueller, 2018; Garcia, 2016; Reeves & Stuckler, 2016) and to better understand how suicide is produced by intersections of race, class, sexual orientation, privilege, and masculinity (Cleary, 2012; Fincham et al., 2011; McDermott & Roen, 2016).

Documenting men's first-person narratives of suicidal behavior is important to give voice to individuals with lived experience, particularly in a field that has hitherto been dominated by biomedical discourses and quantitative epidemiological research (Bantjes & Swartz, 2019). While studying first-person narratives of suicidal behavior holds promise of providing novel insights into a complex aspect of human experience, these methods are not without their limitations and it is not immediately clear how the findings of these qualitative studies can be effectively translated into suicide-prevention strategies (Bantjes & Swartz, 2020). Nonetheless, men's narratives of suicide can reveal how they construct suicidality and how suicidal behavior may be a means of both performing and resisting hegemonic masculinity. Understanding how suicide is bound up in performances of gender holds promise of revealing novel non-psychiatric opportunities for sociologically informed suicide prevention.

Method

This interpretive qualitative study aims to explore the narratives of young men hospitalized in Cape Town following an act of NFSB, in order to understand how these men narrate their experience and understand their own behavior. We have adopted the methodology of "narrative enquiry" (Clandinin & Huber, 2010), which explicitly assumes that people's daily lives are shaped by stories of who they and others are, and their interpretations of past experiences that are recreated through stories (Connelly & Clandinin, 1990). Furthermore, our analysis of the narrative data is undertaken within a constructionist framework that understands gender and gender roles as dynamic, relational, and performative. The data analyzed here are drawn from a larger study in which all self-harm patients admitted to an urban hospital in Cape Town (SA) between June 16, 2014, and March 29, 2015 ($n = 80$) were interviewed with the aim of investigating the sociocultural context of suicide and the organization of care for these patients (Bantjes, Nel, et al., 2017). We have focused here on all interviews with young men because of the homogeneity of this group, the similarities in the stories told, and what these stories reveal about performances of masculinities. Cleary (2005) notes the importance of focusing on homogenous subgroups of men to illuminate how intersecting masculine identities produce men's suicidal behavior. We have published other subsets of the data elsewhere (Bantjes, 2017; Breet & Bantjes, 2017), but this is the first time we present an analysis of this subset of interviews.

Participants

We recruited a purposeful sample of 14 young men who were admitted to a tertiary academic hospital following an act of NFSB. The participants were all between the ages of 18 and 34 years (mean = 25.9, $SD = 4.7$), and they had all sustained medically serious injuries that required in-patient treatment. Three of the participants reported a history of NFSB prior to their current episode (ranging from one to three previous episodes). The sample consisted of eight participants who identified as Black African, three identified as White, and three identified as Colored (an official term used in SA for population classification). Two participants self-identified as gay, and all participants were cisgender. Three participants were HIV+. All the young men had a psychiatric diagnosis; these diagnoses included adjustment disorders, major depressive disorder, substance induced psychosis, and substance use disorder. All participants had been admitted to a public hospital to access state subsidized medical care because their limited financial resources precluded them from accessing private healthcare. The hospital has

a clearly delineated catchment area in the center of Cape Town, and thus all participants were living in the same geographic area at the time of there NFSB.

Instruments

In-depth semistructured narrative interviews were used to collect data. Participants were invited to narrate their experience of NFSB, by asking them how they came to be in hospital and how they understood the context in which their behavior occurred and the factors that contributed to their actions. Participants were asked questions such as: *How did you come to be in hospital? Can you tell me about why you hurt yourself? Can you describe the context or situation in which this behavior occurred? What contributed to your desire to die? What could have been done to prevent this from happening? What will you need when you are discharged from hospital to ensure that this does not happen again?*

Procedure

Participants were approached by the researcher while in hospital and as soon as possible after they had been medically stabilized and were able to give consent. The researcher identified himself as a psychologist who was not part of the treatment team. Participants were informed that participation was voluntary, that their decision to be interviewed would not in any way influence their treatment, and that no private information would be shared with the hospital staff without participants' express permission. No incentives to participate were offered. Interviews lasted between 50 and 90 min and were conducted by the first author, a white middle-aged male registered psychologist, in a private space in the hospital. All interviews were audio-recorded, transcribed, and stored electronically on a password-protected computer.

Ethical Considerations

The Faculty of Health Sciences' Human Research Ethics Committees at the University of Cape Town (352/2016) and Stellenbosch University (N16/02/026) provided ethical approval for the study. In addition, the Western Cape Department of Health and Groote Schuur Hospital provided institutional permission. Participants gave written informed consent prior to data collection and were referred for psychiatric care if they showed any signs of emotional distress as a result of the interviews; all participants were offered the opportunity to debrief with a mental health professional any time they chose after the interview. No identifying details of participants are provided to ensure confidentiality and privacy.

Data Analysis

Data were analyzed with Atlas.ti software using narrative analysis (McAllum et al., 2019). We used an inductive approach, focusing on the content of participants' stories, how the narrative was constructed, how the participant positioned themselves and the roles they assume, the motives of actors involved in the story, the temporal and sequential linking of events, the factors identified as contributing to or precipitating their NFSB, the language and metaphors employed, and the plots. By focusing on the actors and actions, we identified the roles assumed by the young men, along with the role obligations and role expectations. We looked for common narrative themes across multiple interviews, but also gave attention to outliers, counter-narratives, and contradictions. The authors worked independently to analyze the data and then compared and discussed interpretations until consensus was reached. In this way, two dominant narrative themes were identified along with two counter-narratives. Data saturation was reached after analyzing 14 interviews.

Findings

Two overarching dominant narrative themes were identified, namely (1) *Rational action*, and (2) *Escape and control.* Two subordinate counter-narratives were also apparent, namely (1) *It was not me*, and (2) *Defeat and despair*. Each of these narrative themes is presented below using verbatim quotes to illustrate the themes and improve the dependability and trustworthiness of the findings. The use of quotations is kept to a minimum because of space limitations, and pseudonyms are used to protect participants' identities. Although the narrative themes are presented as distinct, they intersect to reinforce and destabilize each other.

Rational Action

In the young men's narratives, NFSB is constructed as a rational decision, enacted intentionally to bring an end to intolerable thoughts and feelings. Participants describe a range of persistent and distressing experiences (which read through a biomedical lens are identifiable as psychiatric symptoms), including intense feelings of sadness, intrusive thoughts, and sensory disturbances. For example, when asked how he came to be in hospital, Charl simply says: "Well, I was depressed about some stuff. So I decided to stop it." And David explains, "I was intensely depressed and disappointed . . . Every time that I've tried to commit suicide that's pretty much the feeling—I don't think you attempt suicide with the hope of surviving it." The young men attribute motivation to a desire to bring an end to distress, imagining that death will bring them

relief. For example, Azola explains his motivation for NFSB saying: "So that's all I wanted to do. I just wanted to end my life so that the voices would just stop. I just really wanted them [the voices] to stop."

In this narrative, participants link their suicidal behavior directly to their thoughts and feelings, positioning themselves as intentional agents and presenting their actions as goal-directed behavior that is rational, logical, comprehensible, and justified. By casting themselves in the role of a decisive action-orientated character, participants align themselves with a hero who actively directs his own life and rescues himself from suffering. For example, Faheem affirms his decisiveness when he explains that he tried to kill himself during a substance-induced psychosis because he thought someone was coming to murder him and he could not tolerate that thought while waiting passively to be killed: ". . ..(I thought) somebody was saying 'I'm going to take your life now.' So, then they tried to force open the door, but it was locked. So, I cut my throat."

Although participants present themselves as tormented by feelings and thoughts, the narrative they construct is one in which they take heroic action to effect change and assert their will. When Charl says "I decided to stop it" and when Faheem says "I decided to cut my (own) throat," they resist being cast in the role of victim. Similarly, Mike presents himself as taking charge of his life, when he says: "So I decided then I wanted to die because I had enough now." Participants justify their actions by pointing to clear precipitants and constructing a linear cause-and-effect narrative, rendering their NFSB comprehensible and logical. By presenting their actions as a choice, participants assert volition.

The unambiguous performance of masculinity in this narrative is striking. Rationality, decisiveness, action, resistance, and taking charge are all hallmarks of hegemonic masculinity, which are foregrounded in the young men's accounts of their NFSB. By foregrounding these elements, the young men employ NFSB to perform masculinity.

Escape and Control

More than half the participants describe being trapped in unbearable situations where they face concrete problems, including interpersonal conflict and economic hardship. Buthalezi, for example, attributes his NFSB to economic circumstances, unemployment, and his inability to realize his aspirations:

> I would say I had enough . . . That time I just felt that things were tough: I can't reach the standards I tried to set myself. Around by this time I thought I would be achieving those . . . it was a social issue.

Jan said: "I was depressed about my job, (and) my wife," and Elijah said: "I could not find a job. . ..It's difficult, especially if you have to provide for yourself."

Participants describe living in difficult circumstances and use violent metaphors like "battlefield" and "danger zone" to characterize their world. Faheem says, "It (life) is very dangerous. People get hurt a lot. Every day they shoot someone dead nearby. If you come out of work, you see there is a body and the police is all over. It is no way to live." By describing a violent landscape where shedding blood is a norm, participants implicitly normalize their own self-directed violence and present themselves as desensitized to death.

Participants position themselves as victims of circumstance and describe facing daily challenges alone and without support in a harsh world. However, as with the previous theme, they speak of having agency in the execution of their NFSB, framing it as "a way out" or as "an escape." Craig, for example, says "I thought that maybe jumping would be the only way that I could get away." And Elijah says, "I was getting away from the situation." Participants describe being stuck in a place where there is little chance of rescue, no hope of relief, and limited power to change the environment. David: says: ". . .that's normally when I lose all hope and just say to myself, 'You know what? Just kill yourself and get it over with.'"

By presenting NFSB as a heroic escape, participants frame their behavior as regaining control and asserting autonomy. Edgar, for example, explains how his NFSB was motivated by a desire to assert control over his mother in a relationship where he felt disempowered: "I was thinking, you know what, I'll show you [by killing myself]." Similarly, Craig, justifies his NFSB saying, "I decided to take control." And Colin asserts his agency explaining, ". . . people wanted to kill me, So I just decided to cut myself."

This "great escape" narrative intersects with the previous narrative, in that the participants narrate themselves as active agents who take heroic steps to end their suffering. As with the previous theme, elements of this narrative can be read as a performance of masculinity—for example, the action-orientation, the decisiveness, and the assertion of control and autonomy. There is, however, a key difference in that here participants are not trying to get away from themselves (i.e., their thoughts and feelings); instead, the young men try to escape their place in the world. Notably, many of the situations that participants seek to escape are ones in which they are prevented from performing traditionally masculine roles (such as earning money, providing for a wife, and protecting themselves from attack). Crucially, participants construct NFSB as a means to perform masculinity in situations where other (nonviolent/self-preserving) performances of masculinity are blocked by circumstance.

It Was Not Me

In contrast to the hyper-masculine rational and heroic narratives outlined above, some participants articulate a counter-narrative by presenting their NFSB as incomprehensible or uncharacteristic. They frame their actions as inexplicable and position themselves as unable to account for their self-harm. Consider, for example, the following exchange in which Khona demonstrates his inability to make sense of his behavior:

> Khona: Then my personality just changed.
>
> Interviewer: Do you remember what happened next?
>
> Khona: I'm not so sure.
>
> Interviewer: Do you remember making the decision to jump?
>
> Khona: No.
>
> Interviewer: Do you think it was an accident?
>
> Khona: No.

Similarly, Chris says, "I just don't know (why I did it)."

Implicit in the words of Chris and Khona is a denial of responsibility and agency. Participants construct an exculpatory narrative by attributing their NFSB to something that is "not me," in so doing distancing themselves from their behavior. Sometimes, this entails denying any intention to die, even when it is apparent that the NFSB was intentional and potentially fatal. For example, Aqeel affirms a desire to live and attributes his NFSB to impulsivity and hasty thinking, implying his actions were a mistake or an error of judgment and hence uncharacteristic: "I am glad to be alive now. I was thinking too fast. . .. I just had the thought and I acted on it." Similarly, Ihmran shifts responsibility and distances himself from his NFSB by pointing to substances and medication as the causes of his uncharacteristic action:

> The reason for that (suicide attempt) was that I became very aggressive . . . It comes from my use of drugs . . . I've also stopped taking my HIV medication. So I've learnt that it's possible that it's from those two combined that I'm here now.

In this counter-narrative, participants imply that they are separate from an irrational behavior and an attempted (that is to say failed) suicide. As discussed in the introduction, irrationality and "suicide attempts" are typically associated with femininity. This exculpatory counter-narrative seems to be at odds with the two former hyper-masculine narratives; however, this counter-narrative can be read as a strategy used by some participants to assert masculinity by distancing themselves from actions that might be perceived as feminine. Participants seem to employ this rhetorical device in the service of shoring up their masculine identities and staving off any insinuation that their NFSB could be feminine.

Defeat and Despair

In this second, much less frequently articulated, counter-narrative, participants describe being too tired to continue and unable to go on enduring hardship. They speak about "giving up" and "letting go," implying that they lacked strength and endurance. They position themselves as defeated, weary, and in need of rest. Buthelezi says: "I was giving up." And Jan explains "Ag, you just kind of feel tired of life and you just want to sleep. So I was just tired. I just wanted to sleep."

Participants talk of hating life and point to multiple losses and grief, explicitly saying that they have nothing to live for, no responsibility to stay alive, and nothing to lose. For example, Edgar says:

> if you hate life so much and if you are tired, why don't you just go and kill yourself? . . . If I die today or any other day, it doesn't matter . . . I'm not afraid of dying because I've got nothing to lose.

And Mike says:

> Yes, I wanted to die, because I had already lost my mother and father, and I know my kids are in good hands. So, I decided then I wanted to die because I had enough now.

The reference to loss and having "nothing more to lose" carries with it images of a loser defeated by life. This counter-narrative intersects with the two dominant narratives in that participants take responsibility for their actions and frame their NFSB as a decision. But the essential difference in this narrative is participants positioning of themselves as vulnerable, unheroic, beaten, and demoralized.

Discussion

The study of men's vulnerability to suicide has hitherto been dominated by macro-level research using quantitative methods from theoretical perspectives that construct masculinity and femininity as binary opposites and conceptualize men as a single heterogeneous group (Cleary, 2012). Our interpretive qualitative study makes a modest contribution toward redressing this imbalance in the literature by documenting men's first-person narratives of suicidal behavior and providing insight into how a group of young men from SA construct suicidality in the way they talk about their experience of NFSB. Our findings help to illuminate how men's suicidal behavior is

inextricably bound up in dynamic performances of gender, which simultaneously reinforce and contest hegemonic models of masculinity.

The men in our study articulate two dominant narratives in which they describe their suicidal behavior as a rational decision, constructing suicide as a hyper-masculine performance of goal-directed action to gain control of intolerable feelings and escape unbearable circumstances. This account of suicidal behavior is congruent with the metaphors of suicide as "arrested flight" and "escape from the self" (Baumeister, 1990; Gilbert & Allan, 1998), and is aligned with the narrative trope of "the great escape." Participants talk about suicide as both a way to rescue themselves and a means of reasserting control in the context of feeling disempowered, positioning themselves as stoic and strong agents who act with decisiveness and intention. These findings echo previous research that links completed suicide to rationality and hegemonic masculinity (Canetto, 1991, 1997; Cleary, 2005). The belief that men should be strong, stoic, and unemotional is deeply embedded in constructions of hegemonic masculinity (Martin, 2016) and has strong links to ideas about the dualism of body (i.e., heart) and head (Whitehead, 2002). This split between reason and emotion is clear in the way the men talk about the decision to end their lives as logical, sacrificing their bodies in the name of reason.

It is noteworthy that the men describe their suicidal behavior as rational and justify their actions as logical efforts to solve a problem. This narrative stands in contrast to the idea that suicide is an irrational and illogical act—the actions of a "mad" person. The concept of "rational suicide" is not new, and the term has been used to denote a mentally competent and responsible adult's well-thought-out decision to end their lives prematurely (Gramaglia et al., 2019; Mayo, 1986), but this concept is more typically applied to euthanasia and in circumstances where an individual has an incurable illness, rather than in the context of understanding the suicidal behavior of young men who are not terminally ill, as in the case with our participants.

It is significant that the dominant narratives frame NFSB as a way to reassert control and exercise resistance, both of which are hallmarks of hegemonic masculinity (Connell & Messerschmidt, 2005), and have been identified as characteristic of young men's performances of masculinity in SA (Bantjes, Kagee, et al., 2017; Bantjes & Nieuwoudt, 2014; Delius & Glaser, 2002; Morrell, 1998; Morrell et al., 2012). Suicidal behavior has been described as an attempt to regain power and assert personal agency (Broz & Münster, 2016; Jaworski, 2010b). By framing their behavior as a rational attempt to assert control and by affirming that they are not afraid to die, participants imply that their actions are heroic acts of resistance, which is in stark contrast to narratives that describe suicide as a sign of weakness. These accounts are, however, congruent with typical media portrayals of political suicides, such as the suicide of Mohamed Bouazizi (a Tunisian street vendor who set himself on fire on December 17, 2010—an act that has been described as a catalyst for the Tunisian Revolution and the wider Arab Spring). By drawing on narratives of power and control, the men in our study imply that they have exercised agency and that their actions are micropolitical. This narrative disrupts the dominant biomedical narrative, which positions suicidal individuals as patients in need of confinement.

The dominant narrative themes we identified are congruent with sociological accounts of suicide as a symptom of "masculinity in crises" (Scourfield, 2005), drawing attention to the gendered nature of suicidal behavior (Canetto & Sakinofsky, 1998; Hawton et al., 2007) and reminding us of the need for suicide prevention programs to be gender specific (Tighe & McKay, 2012). While there is nothing new in our finding that men use suicidal behavior to perform hegemonic masculinity, our data do shed new light on the context in which young men in SA use these performances in reaction to circumstances where the opportunities to take up traditional masculine roles are blocked. The young men describe their NFSB as a reaction to contexts in which they are unable to work, provide for their families, and defend themselves from attack. These situations can be read as potentially demasculinizing, prompting the young men to find an alternative (albeit violent and self-destructive) means of performing masculinity. This finding highlights the need for suicide prevention in SA to include strategies to increase young men's access to employment and provide other avenues for performing self-preserving nonviolent masculinities. One example of how this might be done is a project that uses soccer teams and competitive sport to promote the health of young black men living in resource constrained communities in Cape Town (Rotheram-Borus et al., 2018). Furthermore, this finding reminds us that integral to suicide prevention programs is the need to challenge hegemonic models of masculinity in SA, which prescribe a narrow range of behaviors that young men can use to achieve manhood.

The young men in our study articulate two counter-narratives that contest their dominant account of suicidal behavior as hyper-masculine. In the first of these, they present their NFSB as incomprehensible and distance themselves from their actions by denying responsibility and agency. In the second counter-narrative, they present themselves as defeated by life and in need of help, describing their suicidality as "giving up" and positioning themselves as overpowered, overwhelmed, and having nothing to lose.

One way to read the first counter-narrative is as a rhetorical device in which participants assert that their NFSB "was not me" in order to distance themselves from an action that might be construed as feminine. As noted in the introduction, attempted suicide is typically associated with emotionality, weakness, and femininity (Jaworski, 2010a), and so by distancing themselves from their NFSB, the young men may be defending their masculinity.

In the second counter-narrative, the young men cast themselves as weary and wounded, a narrative that is more consistent with dominant biomedical ideas that suicidal individuals are broken people in need of succor. In this narrative, the young men resist a hegemonic model of masculinity that discourages the expression of distress (Cleary, 2012) and position themselves in a role that allows them to be a patient and to receive help. The inability to express emotions has been identified as a risk factor for suicide (Clare, 2001), but our data suggest that some suicidal young men may be willing to make themselves vulnerable. It is possible that this counter-narrative reflects the context in which our data were collected. All the young men in this study were interviewed in hospital, where they were already receiving medical and psychiatric care. Participants were dressed in hospital "gowns" during the interviews and were thus clearly marked as patients, while the interviewer (i.e., the audience) was plainly identified as a psychologist. It is possible that the demand characteristics of this interview context prompted the participants to narrate their stories in a way that reinforces their status as psychiatric patients and preserves the implicit power hierarchy between interviewer and interviewee.

The narrative data we collected do not allow us to make inferences about what caused the suicidal behavior of our participants (Bantjes & Swartz, 2019). The narratives do, however, suggest that it may be appropriate to support the recovery of these young men by helping them to develop problem-solving skills and enhancing their ability to tolerate feelings. There is empirical support for suicide-prevention interventions that focus on developing patients' problem-solving skills and interventions that encourage distress tolerance and affect regulation (DeCou et al., 2019; Katz et al., 2004; Krysinska et al., 2017; Rasmussen et al., 2014). If we take the narratives of participants at face value, it will seem they are suggesting that problem-solving skills and distress tolerance may aid their recovery and decrease the risk of future episodes of suicidal behavior. It would be helpful if future research could establish if these kinds of interventions would be effective for other young suicidal men in SA.

The study has several limitations, including a small sample size and the fact that data were collected at only one hospital in an urban area. This limits the generalizability of the findings and highlights the need for more extensive qualitative studies in a range of urban and rural settings. The sample is heterogenous in that it includes both gay and straight young men, men with and without a history of suicidal behavior, and men with and without HIV; however, the number of participants in each of these subgroups was too small to allow a meaningful analysis of the differences that might be associated with multiple intersecting identities. There is a need to build on our findings with larger scale studies in SA, which allows for a rich exploration of how cultural norms, economic circumstances, social status, age, and race all shape young men's constructions of their suicidality, as has been done by Cleary in Ireland (Canetto & Cleary, 2012; Cleary, 2005, 2012).

Conclusion

In trying to listen carefully to the voices of 14 young men with personal experience of NFSB, we draw attention to the ways in which they narrate their experiences. Their narratives draw on several tropes including "the great escape" and "heroic resistance." However, participants also articulate a counter-narrative, positioning themselves as defeated and weary anti-heroes who have been crushed by their feelings and circumstances. The findings lend support to the idea that there is not only one narrative of young men's suicide, and that competing and contradictory narratives can be found even within a dominant hyper-masculine narrative. Our findings link to existing literature describing poly-hegemonic masculinities (Sheff, 2006) and showing that young men can simultaneously occupy contradictory positions in their performances of masculinity (Hamlall, 2013). Our data highlight the fact that the way young men understand their own suicidal behavior may not always be congruent with dominant biomedical accounts of suicide. Suicide-prevention messages that are couched in biomedical or psychiatric language may not find resonance with this subpopulation in SA. Crucially, our findings remind us of the importance of gender-sensitive suicide prevention strategies but also caution us against assuming that all young men share a common understanding of suicide.

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