"I should have …": A Photovoice Study With Women Who Have Lost a Man to Suicide

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Abstract

While the gendered nature of suicide has received increased research attention, the experiences of women who have lost a man to suicide are poorly understood. Drawing on qualitative photovoice interviews with 29 women who lost a man to suicide, we completed a narrative analysis, focused on describing the ways that women constructed and accounted for their experiences. We found that women's narratives drew upon feminine ideals of caring for men's health, which in turn gave rise to feelings of guilt over the man's suicide. The women resisted holding men responsible for the suicide and tended to blame themselves, especially when they perceived their efforts to support the man as inadequate. Even when women acknowledged their guilt as illogical, they were seemingly unable to entirely escape regret and self-blame. In order to reformulate and avoid reifying feminine ideals synonymous with selflessly caring for others regardless of the costs to their own well-being, women's postsuicide bereavement support programs should integrate a critical gender approach.

Keywords

suicide, behavioral issues, women's health, bereavement, gender role, gender issues and sexual orientation, caregiving

In Canada, the United States, and the United Kingdom, men account for four out of five suicides (Nock et al., 2008; Payne, Swami, & Stanistreet, 2008; Statistics Canada, 2012). Male suicide has been linked to a variety of factors including substance overuse, history of trauma and family violence, sexual abuse, and distress related to sexual identity (Afif et al., 2008; MacKenzie et al., 2011), and consensus prevails that in industrialized countries, severe depression can flow from such injuries to be a strong predictor of male suicide (Gonzalez, 2008; Canetto & Sakinofsky, 1998; Möller-Leimkuhler, 2003). Unfortunately men's depression is not always recognized and/or effectively self-managed or treated (Oliffe & Phillips, 2008). Within the context of male suicide and those bereaved by male suicide, gender is an important social determinant of health and an essential consideration. Indeed, masculinities and men's health researchers have explored the ways in which dominant masculine ideals shape and are shaped by men's suicide (Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012; Payne et al., 2008). For example, Oliffe et al.

(2012) reported that while men's alignment to some masculine ideals could afford protection against self-harm, others such as alcohol overuse and stoicism heightened men's risk for suicide. Though the body of work in masculinities and men's suicide continues to grow, little attention has been paid to the gendered experiences of those bereaved by male suicide. The current study goes some way to addressing that important knowledge gap by describing the ways that women constructed and accounted for their experiences of losing a male to suicide.

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Gendered suicide and bereavement

There is broad consensus that gender is relational (Butler, 2004; Connell, 1995; West & Zimmerman, 1987), and Howson (2006) has described the ways in which femininities shape and are shaped by masculinities, and vice versa. While gender is coconstructed, contextual, and negotiated within an array of situations, the performativities of individuals are contextualized by idealized dominant hegemonic narratives operating within media, corporations, schools, families, and so on (Connell, 2005; Schofield & Connell, 2000). Within gender and health research, however, the power plays between agency and structure, and the gender relations that shape and are shaped by those interactions are rarely accounted for (Bottorff, Oliffe, Robinson, & Carey, 2011). As Lyons (2009) has argued, masculinities and femininities and their connections and contests have been estranged in health research. Instead, the tendency has been to delink men's and women's health, downplaying and often muting the relational nature of socially constructed gender ideals and the influence on a plurality of femininities and masculinities (Lyons, 2009). While men's health behaviors are portrayed as nuanced and coconstructed (Broom & Tovey, 2009), women (in men's health research) are often treated as a monolithic group, neutral surface, or receptacles. As Bottorff et al. (2011) argue, taking a gender relations approach to health means understanding men's and women's interactions at both individual and institutional level and integrating an intersectional approach that influences the range of men's and women experiences.

In the context of men's suicide, the absence of gender relations work heightens the potential for inadvertently reinforcing stereotypes wherein women are unproblematically assumed to draw on nurturing ideals to look after the health of the men in their lives (Lee & Owens, 2002; Schofield & Connell, 2000). Underpinning this are culturally established feminine ideals about women being vigilant in self-health and keenly orientated to health-care services and connected to specialist providers—practices that emerge in stark contrast to masculinities that position most men as disinterested in health matters and reticent to engage professional services (Mahalik, Burns, & Sysdek, 2007; Smith & Braunack-Mayer, 2006). Building on this gendered disparity in self-health practices, women are oftentimes positioned as the primary purveyors and disseminators of health and illness information for male partners and relatives (Cameron & Bernardes, 1998). While evidence suggests that women positively influence men's health practices (Robertson, 2007; Westmaas, Wild, & Ferrence, 2002), research looking at women as the carers of men finds that there is a cost to women's own health. As Connell (2005) and Schippers (2007)

argue, analysis of women's and men's material relations draws masculinities and femininities out of the symbolic and highlights the ways in which gender relations are constructed through nondiscursive practice. In both the home, where women still do double the housework and childcare tasks (Hochschild & Machung, 1989; Parker & Wang, 2013), and the workplace, where women make up the vast majority of professional caregivers (nurses, social workers, and teachers), caregiving is both socially and economically undervalued (Väänänen et al., 2005). Even in the midst of social and cultural shifts, the degree to which women are judged competent in the care of men is a measure of success—an idealized relationship between masculinities and femininities that endures (Schippers, 2007). This paradoxical position that compels women into relationships of caretaking while simultaneously devaluing it presents mental and physical health risks for women (Väänänen et al., 2005).

When there is lack of a gender relations approach integrated into the analysis of these empirical findings, there can be a tendency to reproduce the notion that this response is biologically driven rather than socially constructed. There is also the hazard that we do not pay attention to the health outcomes for women who choose to (or do not choose to) take care of men experiencing physical or mental ill health. Empirical data focusing on grief and sensemaking following suicide that does not include a gender relations perspective may be oversimplified as "just" the way that any individual may respond to any suicide. When a man is lost to suicide, however, there is potential to question such tactics as well as interrogate the effectiveness of more traditional feminine supports to bolster men's health.

The purpose of this article was to explore women's narratives of losing a man to suicide and to analyze these narratives with a focus on the way that women structured stories and employed narrative devices to highlight the most significant elements of experiences. Because the focus of this analysis was on gender, we paid particular attention to the ways in which participants used such devices to structure masculinities and femininities.

Data and Methods

Individual interviews and photo elicitation methods were used to investigate the experiences of women who had lost a man to suicide. This data was drawn from a larger study in which both women and men who lost men to suicide were interviewed about their experiences. For a more in-depth discussion of some of the ethical issues that we encountered using photovoice methods when researching depression and suicide (please refer to ***blinded for review***). For this analysis we used a narrative methodology, an approach that focuses on the way that

individuals specifically organize and relay life events through storytelling (Reismann, 1993; Sandelowski, 1991). We focused on the ways that participants structured their stories and employed narrative devices to highlight the most important elements of their experiences, with particular attention to the way that participants constructed masculine and feminine identities (Elliott, 2005). While some narratives were not structured with a discernible beginning, middle, or end (Frank, 1996), there was oftentimes a story framework that participants used in order to bridge one event to the next. Drawing from the work of Labov and Waletzky (1997), Elliot (2005) suggested that the central happening, referred to as the "complicating action," is frequently subject to an evaluative act (either implicit or explicit) in which the teller resolves or makes meaning from the selected series of the events in the story. The evaluation can provide the listener with an understanding of why the narrator believes that events have occurred in the way that they have or the events have elicited the response that they did (Elliot, 2005; Hinchman & Hinchman, 1997). When the complicating action is predetermined (such as in the case of a research interview on the topic of a male suicide), participants' sensemaking focuses on the elements of the story that occurred both before and after the event.

Consistent with social constructivist methodologies, our narrative analyses were less concerned with historical fact than with constructions of selves, identities, and social realities in a meaning-making process and with how narrative practices are influenced by the relationship between the narrator and listener (Denzin & Lincoln, 2000). In the analysis of narrative, the audience or the listener are considered coproducers of the narrative (Elliott, 2005; Reismann, 1993). In the current research, while there were variations in age, both the interviewer and interviewee were female. For the most part, they shared a middle-class background. While the interviewer did not volunteer biographical information, in almost every case, participants were interested to know if she too had lost a loved one to suicide. When asked, the interviewer disclosed that she had lost a distant family member to suicide. In addition, the fact that both the interviewer and interviewee were female likely shaped what transpired in the interview space. As Holland and Ramazanoglu (2005) state, women are socialized to share the details of their emotional world with other women. These variables inevitably shaped the way participants constructed their stories, though not necessarily in predictable or consistent ways.

Our analysis of gender and gender relations was based on the work of Schippers (2007) who adapted Connell's seminal work in the study of multiple masculinities to examine femininities. Schippers's work is particularly relevant as it situates masculinities and femininities within the gender hegemony, allowing for multiple configurations and applies an intersection lens. Through the everyday practice of storytelling—in this case about a man's suicide—women illustrate Schippers's theoretical lens on the production, proliferation, and contestation of the social construction of femininities. What makes a gender relations analysis so interesting in the context of narrating the experience of losing a man to suicide a gender relations analysis is interesting. It presents an opportunity to observe the ways in which the narrator's discussion of human emotions such as guilt regret and self-condemnation is a construction of relational gender identity.

With reference to the important role that social norms, ideals, and practices play in the way that narratives are positioned (Hammack, 2011), we took into account some of the realities of the Canadian urban and rural settings in which the interviews were conducted. In these settings, suicide rates are strongly gendered, social stigma surrounds men's mental illness and suicide, and men are often reluctant to seek support for mental health issues. These realities, therefore, informed our analysis. For example, we paid attention to the way that women constructed their own feminine identity in tension with the masculine identity of the deceased. We also focused on the ways in which women, as individuals who stepped forward to participate in a study on male suicide, engaged the issue of stigma.

Following ethics approval from (Behavioural Research Ethics Board at the University of British Columbia), participants were recruited by way of postcards and posters made available at a variety of locations and notices disseminated online through social media platforms (Facebook, Twitter) and on Craigslist. The study details were shared in both rural and urban contexts with the leaders of suicide support groups and funeral home counselors and at student support services to disseminate as they saw fit. Participants were invited to contact the project coordinator if they were interested to share their stories about having lost a man to suicide. Inclusion criteria of 19 years or older, English speaking, and resident of Canada guided participant recruitment.

At the outset, we aimed to recruit at least 20 participants and continued to interview until we agreed that saturation had been achieved. Twenty-nine women, ranging in age from 19 to 74 years (mean = 43 years), who had lost a man to suicide participated. Women self-identified as Anglo-Canadian ($n = 24$), South Asian ($n = 3$), Chinese ($n = 1$), and First Nations ($n = 1$). Twenty-five participants identified as heterosexual, three bisexual, and one lesbian. We were unfortunately unable to recruit a cross section of participants from different cultural and ethnic backgrounds. Women, however, had diverse relationships

to the man who had died: seven mothers, seven sisters, five friends, three daughters, two wives, two girlfriends, one cousin, one aunt, and one niece. Participants resided in urban ($n = 16$) and rural ($n = 13$) Canadian settings.

Data Collection

Eligible participants met twice with the researcher. The purpose of the first meeting was to obtain written consent and demographic information as well as to explain the photo elicitation assignment. Participants were invited to take a series of photographs to tell the story of the suicide with a focus on how the suicide impacted them. Participants took up to 2 weeks to complete the photographs in preparation for a second interview—lasting 1 to 3 hours—focused on the participant-produced photographs.

At the beginning of the second interview, the researcher removed the memory card from the participant's camera and loaded the images onto a laptop computer so that both the researcher and participant could view the photographs. Women were first invited to tell their stories using the images as a guide, the researcher only interjecting with questions for clarification or elaboration. Following the participant-led story, the research interview began with open-ended questions: "What was your relationship with the deceased like leading up to the suicide?" "What were your initial reactions on hearing the news of the man's suicide?" If the participant did not spontaneously bring it up, the researcher asked her to reflect on issues of gender, "Why do you think men take their own lives in higher numbers than women?" The interview concluded with more open-ended questions about participants' ideas on what might be done to prevent men's suicides.

Data were collected in 2014. Interviews were conducted by a trained female researcher. Participants either received $200 ($100 following each interview) or a digital camera to be used in the study and $100 (following the second interview) to acknowledge their contribution to the study. While the honorarium offered to the participants was significant, we felt it was justified given the time and effort involved. Participants were provided with contact information for professional grief and crisis intervention services. Interviews were digitally recorded, transcribed verbatim, and checked for accuracy. All the transcribed interviews were anonymized by removing potentially identifying information, and participants' interview transcripts were allocated a numerical code (i.e., W1–W29) and a pseudonym to link specific photographs and narratives to the inductively derived study findings.

Data Analysis

We approached the data with a gender relations lens, paying attention to the way that women aligned with and contested social constructions of femininity in the way they described bereavement related to suicide. Our data analysis was guided by Elliot's (2005) framework for extracting and interpreting narratives. We began by reading and rereading the interviews to gain an impression of the narratives in their entirety. The first and second authors made notes on each interview that outlined the ways that the participant framed the story of the suicide and the events, relationships, and messages she chose to highlight. We then used NVivo qualitative software to extract from the interview data emergent important sub-narratives: how women positioned the suicide as surprising or expected, how they viewed the man who died by suicide, and the way that they constructed their relationship with him. With these contextual details, we further mined the data for instances in which participants narrated their response to the death, paying attention to the ways that women described subject positions that relied on or contested master narratives of femininity with respect to women's caretaking of men's health. We also explored how masculinities were constructed and used by participants to make sense of the suicide of the man. Consensus about the findings and their organization were developed through discussion among the authors and in the cowriting of this article.

Photographs were used in the analytic process not as separate data, but for the way that they helped the participants to tell their story and give depth and breadth to the narrative. We noticed early on that the photographs helped to convey the tenor of the story; for example, photographs devoid of life helped to convey the sense of emptiness while images showing beautiful nature scenes were often intended to signal and signpost hope. Photographs were often used by participants to convey a metaphor, for instance, a mask surrounded by words to reveal a participant's perception that her brother veiled his depression with performances of self-assurance and happiness.

Findings

Our analysis revealed the ways in which women aligned their personal narratives with femininities and masculinities to anchor and make sense of losing a man to suicide. The suicide of their loved one was the *complicating action* or event in these narratives. Punctuated with significant loss, women's narratives were grounded in the close and meaningful relationships they had with the deceased. As their stories unfolded, all of the participants talked about profound feelings of regret that they had failed to identify and address the issues or telltale signs underpinning the suicide. With reference to dominant ideals of femininities wherein women are expected to take responsibility for the health of men (Ellis, Griffith,

Allen, Thorpe, & Bruce, 2015), strong feelings of guilt that they had somehow failed in their role dominated their stories. While expressions of guilt, often revealed in the phrase "I should have . . . ," were overarching, there were variations in the focus of the guilt that appeared to us to be linked to whether the suicide was constructed as a surprise or somewhat expected. The three most dominant narrative themes reflecting the way participants positioned their feelings of guilt and regret were (a) *I should have known*, characterized by women's self-reproach, and the reproach of other women, for not being sufficiently attentive and watchful, (b) *I should have tried harder to save him*, wherein women suggested they should have saved the man, and (c) *I should have been there for him no matter what*, a position lamenting their tough love attempts to help the deceased and the abandonment of a softer, selfless nature focused on the care of others. Each of these narratives is described, contextualized with literature that we considered relevant to the way that women framed the suicide. With the permission of the participants, we have included several illustrative quotes and photographs linked to participant pseudonyms to show the tenor of the narratives within the findings.

I Should Have Known

In this story line, the narrator reveals that the suicide came without warning, leaving the survivors shattered by the death. In some cases, to emphasize that the man who died was the "last person" they would have considered to be at risk for suicide, women focused on the profound shock they felt at hearing the news of his death. When the death appeared to "come out of nowhere," participants used words like "jolted," "immobilized," and "hit by a bomb" to describe the way that the unexpected suicide figuratively shook them. In the narrative, *I should have known*, a story of ever-present guilt dominated as women drew compelling connections between this unexpected suicide and not being sufficiently observant and therefore aware of the potential for such a tragic event.

There was a commonality in the way that women who articulated this narrative were in relationship to the deceased. In all but one case, the man was younger than the woman was and at some point, he had literally been under her care as a younger sibling or son. In the case of Naomi, while her brother had been older, his difficulty engaging with "other humans" had placed her in an up-front role when it came to social encounters with the outside world. Thus this narrative theme "I should have" is consistent with their sense that they had faltered in their care, seen only strength, and had failed to enquire into vulnerability.

To further reinforce the storyteller's perceptions that suicide was unexpected, women provided detailed descriptions of the exceptional accomplishments of the men, supporting their observations with photographs and evidence signaling their closeness to the deceased. For example, Lauren, a 23-year-old from a small urban center, began her story by describing her brother's death as "completely out of the blue." She recounted that her brother was about to finish grade 11 in the small town that they grew up when her mother came home to find his lifeless body hanging from the rafters in the shed. She saw her brother as a young man full of energy, a person whom she had thought was eagerly making plans for the future. Lauren took a photograph showing her brother's pictures and trophies to illustrate his full and successful life, along with the accompanying narrative (Figure 1).

> He was 17 and a total golden boy. He captained a bunch of sports teams and did really well in school, and had a lot of friends and we had a pretty like, idyllic childhood, rural upbringing [with a] close family [and] lots of extracurriculars.

Eliana, age 20, was only 14 when her 15-year-old cousin hung himself in the bathroom. She too constructed the deceased in glowing terms: "He was always just the happiest, kindest person and he had perfect marks. He was the best player of every team sport. No one had any idea that was going to happen." He was positioned as very much a "golden boy" who others considered to be a role model.

Lauren, Eliana, and several other participants described the deceased as embodying dominant masculine ideals wherein they were revered and respected as successful young men. The adjectives used such as "strong," "bright future," and "golden" contrasted sharply with constructions of a man whom one might consider to be at risk for suicide, such as helpless, despairing, damaged, or tarnished. Indeed, when the women thought back, trying to find a behavior or a potentially overlooked warning sign, neither Lauren nor Eliana and their families had much to offer beyond the vaguest signs that things were not as they seemed. Lauren wondered if her brother had tried to banish a depression through an overinvolvement in sports or if his difficulties with math had overcome him. Eliana found a poem that her cousin had once written that referred to a heart monitor stopping and she questioned if this was evidence of a muted cry for help so often linked to suicide. At the same time as each reflected on the incomprehensibility of the suicide, they berated themselves for being taken in by the man's efforts to conceal his depression. The phrase used by Lauren "blinded by his brightness" was reflected in the sentiments of
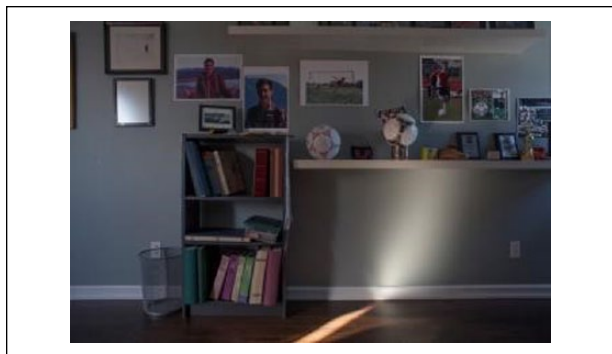
Figure 1. His Bright Future.

Figure 2. He was my son.

others when they regretfully identified possible indicators of unhappiness.

In Naomi's story about her brother, who at age 21 years died by self-asphyxiation, she also emphasized his exceptional talents.

> He was pretty much the smartest person I've ever known, like all throughout high school he just got—well, especially in mathematics and calculus and stuff, he was always—he was getting like, over 100% because he'd always get the bonus marks.

While Naomi recalled that her brother was always different from the other kids his age, he had a strong circle of friends with common interests. While he generally "preferred cats and music to other humans," he had a girlfriend and seemed to be happy living in shared university housing with his friends. Despite residing in different cities, Naomi considered her brother to be a "close" friend. Even the week prior to his death, she and her brother had exchanged text messages: "He would just ask how things are going, and it was—there was even like, 'Oh, I can't wait to see you,' you know, 'in summer,' and I'm like, 'Oh yeah, me too!'" Naomi wept during the interview, mourning her brother's death and trying to recall if he might have been attempting to signal his feelings of depression. The strong rapport with her brother added to Naomi's burden that she should have known her brother was at risk for suicide: "And this is weird but there's a part of me that feels, like, guilt because I was his sister and we were the ones that talked." In this story line, the complicating event of suicide was nestled with an evaluation that Naomi *should* have noticed her brother's depression and that she would have, if she had looked and listened more intensely.

In the case of Naomi, while her brother had been older, his difficulty engaging with "other humans" had placed her in an up-front role when it came to social encounters with the outside world. Thus this narrative theme "I should have" is consistent with their sense that they had

faltered in their care, seen only strength, and had failed to enquire into vulnerability. It is, of course, debatable as to whether even if they had looked for it, they could have deciphered that the man was suicidal. These women, nonetheless, condemned themselves for not seeing it. They measured themselves against dominant social ideals of femininity, which include observance skills and the ability to accurately understand and appropriately respond to men's moods. While the men featured in these narratives were positioned as being self-reliant and stoic about troubling matters of inferiority (i.e., depressive symptoms, suicidal thoughts), women expected to be able to differentiate the man from the "mask" being used to conceal his vulnerabilities.

Several participants extended a feminine subject position of women's watchfulness over men to the mothers of men who had died by suicide. Whether or not participants recalled the mother articulating feelings of guilt, mothers were narratively located at the nexus of the suicide. For example, with her permission, Naomi shared a photograph (Figure 2) of her mother foregrounded by the caption "He was my son" in saying, "*My mom felt terribly guilty. She always says you 'shouldn't have to see a child die before yourself'.*"

In contrast to the way that she positioned her mother and herself, Naomi never linked her father's grief to such guilt. Instead she described her father as tearful at first and then stoic.

> I think his main concern was being strong for the family and to get everyone through the tragedy. I don't think he thought of it as his fault that my brother died but he wanted to make sure that there was someone to hold [participant and participant's mother] together.

In summary, a dominant theme within this story line is the "out of the blue" nature of the men's suicide amid ever-present guilt that somehow women central to the men's lives should have known and therefore done more
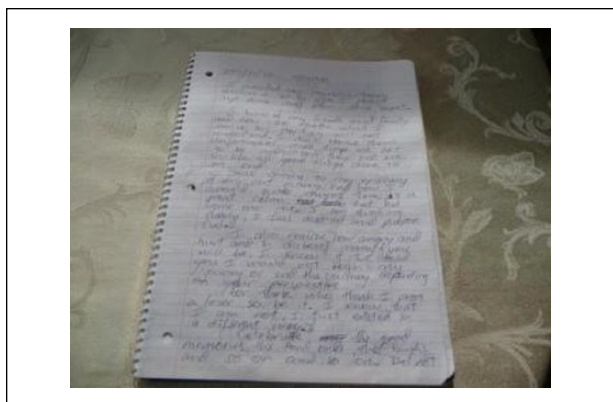
Figure 3. Final Words.

Figure 4. Rainy Days.

to protect *their* man from suicide. The shadow data wherein mothers were understood by participants to be especially vulnerable to the futile torment flowing from a *mother's* lack of knowing confirmed the heavy weight invoked by dominant discourses of femininity on many participants—and the women around them.

I Should Have Tried Harder to Save Him

In other stories, men died by suicide after a long struggle with mental illness, primarily depression. In these cases, women had been in a supportive relationship with the man, often making a number of attempts to find help and resources. In the narrative "I should have tried harder to save him," the women's guilt revolved around not working hard enough to find the right resources amid constructions of men's helplessness in the face of depression. Women positioned themselves as caring and responsible caregivers in the lives of men suffering from depression, often pointing to shared actions and emotions to emphasize their closeness and attentiveness. Phrases such as "When he was up, I was up. When he was down, so was I" and "I waited with vigilance every morning to see his

mood" were common ways to describe the interconnectedness women felt with the man they were caring for. The women's dedication was reinforced with accounts of their relentless efforts to find help and resources. When the man died by suicide, women described the bereavement as filled with a sense of failure, tremendous guilt for not doing enough, and the loss of an essential part of themselves. As one woman described it, "I was left holding air where I once held my son."

Nancy began her story by explaining that she always understood that her 31-year-old son, Mark, was different. Unlike his younger brother, who seemed to "glide through life," Mark was sensitive, spending hours brooding when he felt slighted by others and becoming undone when a project that he was working on didn't turn out as perfectly as he would have liked. Mark was well liked by his many friends and an accomplished athlete, never sharing his sadness or feelings of impending doom with anyone other than his mother. Nancy demonstrated her intimate knowledge of Mark's struggles, sharing how "he would be so jolly sometimes, he'd come home and light up the room while other days he could not leave his bed." When Mark was 13, Nancy recalled taking him to her general practitioner to discuss what she was certain was depression, but the end result was assurances that Mark was "just fine."

Positioning herself as relentless in her efforts to get her son the help he needed, she recounted how she took him to counseling and psychiatrists only to be told that Mark was developing normally. Undeterred by those who thought her overinvolvement in her son's life was unhealthy, Nancy explained that she continued to offer her son unlimited time, encouragement, and support:

> It was almost like breathing life into him, you know—willing him to live, because there is nothing—nothing more painful—[Starts to cry.]—than to lose your child. The one that you gave birth to, that you looked after, you nourished, you devoted your life to, to find they don't want to live— when I wanted him so much to live.

Nancy constructed Mark as a responsible and caring young man who tried to reassure and comfort others in the face of his decision to take his own life while attending to details by leaving a voice message about where they could find his body. Nancy shared a photograph (Figure 3) of Mark's suicide note as an example her son's thoughtfulness, releasing her from responsibility for his life and death. Mark wrote, "I knew that if I told you, I would not begin my journey, or end the journey, depending on your perspective."

Nancy was consumed by guilt and anger, not toward Mark but instead these feeling were self-directed. Her 24-year effort to keep Mark alive was "not enough" and she agonized over and over again about what she should and could have been done differently, including finding a

Figure 5. Wall of Shame.

more vigilant psychiatrist and a school system better equipped to recognize and treat mental illness and grooming a girlfriend for Mark, who would be "less selfish" (punctuating her belief that women—not only herself—were to be selfless caregivers).

While other participants followed a similarly structured narrative of caring for a depressed man in every way they knew and then still blaming themselves after he died, one participant's story was more complicated. Chelsea was one of the few participants whose story involved actively resisting the responsibility for saving men from suicide but ultimately being unsuccessful at fully resisting feelings of guilt. Chelsea described how a highlight of her relationship with Adam, her 27-year-old boyfriend, was sharing a cross-country bike trip. She recalled that when she left the trip to go back to work, he continued on but sent her daily photographs and updates from his travels "as though he took me along with him." Soon after he returned from his journey, however, Adam became moody and withdrawn. Eventually, Chelsea confronted him, recounting the following;

> He said, "I am nothing," and I said, "What do you mean?" and he said, "I am nothing," and he was just crying and crying and I remember there was a moment where I thought, I don't know what to do. I don't know what to say, this is—it's late, you know, it was something like 2 o'clock in the morning or something, and I thought, you know, whatever it is I have to just trust that he knows how to look after himself. He's a grown up man, and I left—I left him be.

It was a few weeks later that the police knocked on her door to inform Chelsea that Adam had died from self-inflicted carbon monoxide poisoning. Her narrative of the grief was punctuated with conflicted feelings about what had happened. On the one hand, she explained how angered she was when people would ask her if she felt responsible for Adam's death, "So when people say, 'Oh, do you feel guilty?' you know, I have to say, 'About what? What are you suggesting I feel guilty about?' It's ridiculous."

Later in the interview, Chelsea admitted to insidious feelings of guilt and regret. She took a photograph of a card that she had made and given to Adam as a show of support. When the police found Adam's body, he was still clutching the card (Figure 4). Chelsea lamented that when she read and reread the card, she could not shake her concerns that she hadn't written the right words and more profoundly that she hadn't been the right kind of girlfriend for him. She interpreted the message as she thought he might, as giving him space rather than "worrying and fussing and infringing myself on him." Her perspective had been that he was an adult, able to care for himself, and make his own decisions.

> Maybe that's guilt. Yes, I do feel guilty. It feels sad, and embarrassing and this is one of the things that hurts me the most, is—it shows how much I cared, it shows me trying to reach out to him, in what now seems like a really useless way, and that he brought it into the car with him.

Chelsea constructed herself as deeply "embarrassed," both by her seemingly insufficient efforts to keep her boyfriend from killing himself as well as by the presence of her card and note of support at the scene of the suicide. Her story illustrated how pervasive narratives of femininity can be, wherein rational assertions about her well-intentioned efforts to support Adam as best she could were brought into question by others, and ultimately herself. Evident in the "I should have tried harder to save him" theme were participants' tensions between conceding their inability to prevent *their* man's suicide despite knowledge of that risk.

I Should Have Been There for Him No Matter What

In contrast to the previous two themes, a very few number of participants spoke openly about the lifetime of trauma experienced by the man who died. In these stories, the women described men as struggling, not only with

mental illness prior to their suicide but with an array of other issues including abuse, abandonment, intense bullying and harassment, substance overuse, loneliness, and homelessness. In the context of facing hardships in their own lives, these women made attempts to provide support wherever and whenever they were able to. In the narrative theme "I should have been there for him no matter what," women's stories highlighted the struggle they experienced with their knowledge of men's needs for support and the burden of providing care, which ultimately had become too great. They had made the decision to move away from a toxic and sometimes abusive relationship with the man, because this decision was deemed by these participants as being positive for their own mental health and it offered them a sense of emancipation. They described the reason for the distancing with phrases such as "I needed to move away for self-preservation" and "His toxicity didn't allow me to move on." The suicide, unfortunately, drew them back into emotional entanglement with the man, which they found to be even more complicated to resolve in his death. Phrases to describe their current situation were such as "I felt such shame" and "I didn't nurture as I should have." The narratives were tragic, as emancipation from traditional feminine ideals by putting their own health concerns first was regressed by guilt that they had been too quick to depart from selfless caregiving.

Addison's story began with a description of her brother Michael who was adopted by her family when he was 4 years old. Addison explained that her adopted brother had likely experienced a very traumatic experience prior to coming to live with her family. To illustrate this, she told a story of his first birthday party with the family in which he spent most of the event crying behind the couch. She hypothesized that he was overwhelmed by the attention and love shown to him for the first time in his young life: "Yeah, and if he had been abused—I mean, I don't have any clue whether that's real or not, but if he had been, I can imagine the shame and the loneliness he would have suffered."

Addison narrated her own memories of the significant trauma that she had experienced over the course of her childhood. She told of being molested by several men including her next-door neighbor as well as instances of poverty and not having enough to eat. She described that one of the darkest experiences of her childhood was when her mother discovered that her stepfather was a pedophile. Her mother left, taking her two daughters with her but was forced to leave her adopted son behind. Addison noted that after this family fracture, she and Michael saw very little of each other. On one occasion, in a rare interaction, Michael was sexually inappropriate toward her and Addison decided to avoid him thereafter. Addison suspected that Michael's life had become very difficult.

As a young adult, Addison heard through family and mutual friends that he had taken his own life:

> I felt very shamed about it, that I couldn't help. That I was—well, it wasn't about me, but you just feel like, what kind of a crappy sister or family member was I that he couldn't have reached out to me—or called—it made me aware that, you know, I'd really lost my ability to interact with him.

Despite her own experiences of violence and trauma, Addison talked about the ways in which she still felt responsible for ensuring her brother's well-being. In her own description of womanhood, she included the responsibility of being a resilient caregiver. She had two photos of herself superimposed over a grassy field, adding the words "Wall of Shame." (We have anonymized these photos to protect Addison's identity as a survivor of sexual abuse [Figure 5].)

> It could be the nature of who we are, and our role in society—again, men are supposed to be the tough guys that are the bread winners or take care of everyone, we're [women] the ones who are supposed to be nurturing and supportive and communicative.

Addison's story reflected the accumulation of risk factors for suicide that can occur in families with poverty and violence. Addison's narrative is characterized by shame in spite of, or perhaps because of, the victimization she personally experienced. She used phrases such as "I was a crappy sister" to explain the reasons why her brother may have failed to reach out to her. While she described her awareness of the difficulties that they had both experienced throughout their childhood, her strongest narrative was that of believing she should have been there for her brother no matter what.

Linda spoke about her son Allan who died when he was 20 years old, lamenting the primary cause of death being her lack of "mothering" at the end of his life. She described her son's difficult childhood, the ways that he had been picked on and excluded from friendship groups at school. She attributed his inability to "fit in" with the other kids to the fact that he was smaller than the other boys and from a family of new immigrants who were financially disadvantaged. Unable to speak enough English to talk to the school about Allan's situation, she attempted to "talk him through it" at home. Ultimately, Linda conceded she was unable to alleviate his sadness. She took a photograph that illustrated a bleak life in their new rural Canadian home and described how this scene represented her feelings of "isolation" and the "coldness and hardness" that she experienced from others in the community (Figure 6).

Linda described how upon graduating from high school, Allan moved around attempting to escape his misery. Linda helped him to move out of Canada—back to his parents' birthplace, Switzerland—but he was

Figure 6. Bleak Winters.

unable to make friends or find a good job. He moved back to Canada to a nearby city and applied for technical school. Linda recalled that he became unhappy there too, saying that he felt "scared and overwhelmed." She remembered Allan calling her to say that he wanted to move to Australia. For Linda this was "the last straw." In "frustration," she told him that he needed to remain in school because he had worked so hard to get in.

Linda's story led up to a crescendo wherein she described receiving a telephone call informing her that Allan had killed himself. Her story had included multiple instances in which she had helped her son by talking to counselors, supporting his relocations, and spending hours on the telephone discussing his sadness. However, this support was contrasted with her frustration and expression of that to Allan. She explained that the very moment she had strayed from her usual response, he died. Linda framed her response as "impatience" and described how both she and her husband thought of her failure to persist in being patient with Allan contributed to his death: "I think, and my husband thinks, that I failed at my one job, to take care of my family. I wish I didn't say that [that her son couldn't leave school]."

Notwithstanding the patriarchal overtones in the father assigning blame to Linda as the inept mother to Allen, Linda simultaneously conceded her failure to live up to her parenting role. The virtue of patience, lost in Linda's case, and the lack of care and comfort on Addison's part (despite knowing of Michael's struggles) weighed heavily on them despite the limits and boundaries of their support for the men. This strong narrative frame also renders insignificant the women's health and well-being.

Discussion and Conclusion

The findings presented here demonstrate how stories can act as a medium for deeper awareness about phenomena. As one of the first studies to focus on understanding meanings represented in women's narratives of losing a man to suicide, the narratives uncovered provide important insights into women's experiences, the profound guilt that dominated their lives, and the influence of gender relations. Even when women acknowledged their guilt as illogical, they were seemingly unable to entirely escape regret and self-blame. These findings have important implications for promoting mental well-being for both men and women.

One of the most commonly articulated strategies in men's health promotion is to engage the women in men's lives as conduits to advancing men's health and more specifically, in their health help seeking and illness self-management (Sandovsky, 2005; Sharpe, 2002). Though well intentioned, the findings from the current study caution the recruitment and/or positioning of women in these ways. Alongside the pressure internalized by many women to act as intermediaries between men and mental health-care services (Hennessy & McNamara, 2014), ideals about women being remedy makers for men's mental illness are also reinforced. As evidenced in the current study findings, taking up such feminine ideals can significantly burden women in the lead up to both male suicide and/or the complicated grief that can accompany the aftermath of such tragic events. Extending on these insights, the current study reveals male suicide as acutely inciting or exacerbating women's guilt for failing to take care of a man lost to suicide, as evidenced by the potentially everlasting and languishing "I should have" narratives. Of course, excluding women from men's health also poses significant risk, especially in mental illnesses such as men's depression and suicidal behaviors, because men don't necessarily have insight to their illness and/or effective strategies for addressing those issues.

The suicide of a significant friend or family member constitutes an emotional crisis. Not only did the women experience loss and grief, but also the suicide significantly interrupted their sense of self. As has been described elsewhere, the women we interviewed endorsed feminine ideals about being vigilant in self-health and positioned themselves as the primary purveyors and disseminators of health and illness information for male partners and relatives (Cameron & Bernardes, 1998; Mahalik et al., 2007; Smith & Braunack-Mayer, 2006). Unlike the findings of Oliffe, Kelly, Bottorff, Johnson, and Wong (2011) that focused on women and men's depression, the women's narratives in this study did not challenge traditional feminine support roles. In the wake of a suicide, beliefs about being able to perceive their significant other's emotional state, to heal his depression, and to assist him in saying "yes" to life were disrupted. In the face of this crisis, the women's narratives reveal important information about their coping strategies. For example, an important way that they managed the loss was to hold themselves accountable for preventing the death. Findings from this

study suggest that aligning themselves with traditional feminine ideals that promoted an ethic of selfless caring and self-sacrifice was detrimental to healing from grief and loss. Grief counselors might consider framing guilt following suicide as "maladaptive" (Li, Stroebe, Chan, & Chow, 2012) and using feminist-informed approaches framed by an analysis of oppressive gender constructs (Evans, Kincade, & Seem, 2011).

Bearing the aforementioned issues in mind, clinical practice might benefit from gender-specific and gender-sensitive interventions to (a) address women's self-expectations and grief, and (b) advance men's suicide prevention programs. In terms of addressing women's self-expectations and grief, bereavement counseling might benefit from knowledge about the gender relations–related findings detailed in the current article in thoughtfully interpreting and intervening to quell some of the reliance on and rumination about omnipresent feminine norms in and around male suicide. For example, indelibly linked to the participant narratives are dominant ideals of femininity that canvass nurturing of and self-sacrifice for men as much-revered womanly qualities. Making available alternatives to these long-standing feminine ideals amid honoring the memory of the deceased might waylay some of the ruminating guilt, regret, and remorse that dominated the narratives and the lives of the participants. Explicitly contesting scripted ideals about what women should and routinely do to look after the health of the men in their lives could similarly afford some respite and remedy to reconcile the suicide and accept the event as residing outside the women's control. Such strategies akin to Butler's (2004) assertion round the need to undo gender are critically important within the context of counseling for women survivors of male suicide. In terms of male suicide prevention programs, operationalizing "guys helping guys" approaches could also garner significant benefit. Two principles underpinning this model are that (a) men don't "go it alone" but instead connect with other men to engage mutual help and (b) male peer support models embody critical and complex approaches to gender (Seebohm, Munn-Giddings, & Brewer, 2010). Work with returned soldiers (Westwood, McLean, & Cave, 2010), men's smoking cessation (Bottorff, Johnson, Irwin, & Ratner, 2000), and men's mental health (Robinson, Raine, Robertson, Steen, & Day, 2015) indicates that men have the capacity within groups and through virtual platforms to effectively advance the health and illness practices of other men. Applying such approaches to men's severe depression and suicidality might concurrently reduce some of the pressure on women amid mobilizing men's peer-supported self-management strategies to reduce male suicide.

It is worth pointing out that in identifying themselves as responsible for the death, women constructed men as being less able or equipped to care for themselves. This contrasts with socially idealized masculinities in which men are represented as strong, invulnerable, and independent. However, when women narratively constructed men in ways that have linkages to idealized masculinities (e.g., focusing on men's accomplishments), as they did in the narrative "I should have known," they did not question why these strengths did not translate into men being able to take care of themselves. Amid the complexity of gender dynamics, these contradictions appeared to be overlooked by the women, as well as the possibility of restrictions on the performance of alternative masculinities that are compatible with self-care. Also not recognized in these narratives is that increasingly men are talking on new roles and responsibilities and in doing so, are negotiating and experimenting with new forms of masculinity including traditionally feminized qualities such as caring for self and others. These findings indicate, however, that conventional notions of masculinity are still influential and that women play a role in perpetuating outmoded masculinities, thereby limiting the range of acceptable possibilities for men.

Conclusion

The connections between male suicide and the health of women, family, and friends are especially evident in the findings drawn from the current study. While gender and health work routinely, yet naively trades on sex differences to make comparative and oftentimes competing cases for women's *or* men's health, the context of male suicide and female survivors demands actions to break with such binaries and to explicitly name suicide as a significant men's health issue and collectively do the work of male suicide prevention as a means to bolster both men's and women's health. In sum, *we* should all seek to address male suicide as a means for achieving the much-cited promissory notes embedded within the "health for all" ideals (World Health Organization [WHO], 2005).

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References

Afif, T. O., Enns, M. W., Cox, B. J., Asmundson, G. J., Stein, M. B., & Sareen, J. (2008). Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences. *American Journal of Public Health*, *98*(5), 946–952.

Bottorff, J. L., Johnson, J. L., Irwin, L. G., & Ratner, P. A. (2000). Narratives of smoking relapse: The stories of postpartum women. *Research in Nursing & Health*, *23*(2), 126–134.

Bottorff, J. L., Oliffe, J. L., Robinson, C. A., & Carey, J. (2011). Gender relations and health research: A review of current practices. *International Journal for Equity in Health*, *10*(1), 60.

Broom, A., & Tovey, P. (2009). *Men's health: Body, identity and social context*. Sussex: John Wiley & Sons Inc.

Butler, J. (2004). *Undoing gender*. New York, NY & London: Routledge.

Cameron, E., & Bernardes, J. (1998). Gender and disadvantage in health: Men's health for a change. *Sociology of Health and Illness*, *20*(5), 673–693.

Canetto, S. S., & Sakinofsky, I. (1998). The gender paradox in suicide. *Suicide and Life-Threatening Behavior*, *28*(1), 1–23.

Connell, R. W. (1995). *Masculinities*. Cambridge: Polity Press.

Connell, R. W. (2005). *Masculinities* (2nd ed.). Berkeley, CA: University of California Press.

Denzin, N. K., & Lincoln, Y. (2000). *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publication.

Elliot, J. (2005). *Using narrative in social research*. London & New Delhi: Sage Publication.

Elliot, J. (2005). *Using narrative in social research: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publication.

Ellis, K. R., Griffith, D. M., Allen, J. O., Thorpe, R. J. Jr., & Bruce, M. A. (2015). "If you do nothing about stress, the next thing you know, you're shattered": Perspectives on African American men's stress, coping and health from African American men and key women in their lives. *Social Science & Medicine*, *139*, 107–114.

Evans, K. M., Kincade, E. A., & Seem, S. R. (2011). *Introduction to feminist therapy: Strategies for social and individual change*. Thousand Oaks, CA: Sage Publication.

Frank, A. (1996). *The wounded storyteller*. Chicago, IL: University of Chicago Press.

Gonzalez, V. M. (2008). Recognition of mental illness and suicidality among individuals with serious mental illness. *Journal of Nervous and Mental Disease*, *196*(10), 727–733.

Hammack, P. I. (2011). Narrative and the politics of meaning. *Narrative Inquiry*, *21*(2), 311–318.

Hennessy, M., & McNamara, P. (2014). Gendered perspectives of men's health and help seeking: Implications for public health and health promotion. *International Journal of Medical Health Sciences Research*, *1*(2), 12–28.

Hinchman, L. P., & Hinchman, S. K. (1997). Introduction. In L. P. Hinchman & S. K. Hinchman (Eds.), *Memory, identity, community: The idea of narrative in the human sciences* (pp. xxiii–xxxii). New York, NY: State University of New York Press.

Hochschild, A., & Machung, A. (1989). *The second shift: Working families and the revolution at home*. New York, NY: Penguin Group.

Holland, J., & Ramazanoglu, C. (2005). Coming to conclusions: Power and interpretation in researching youth women's sexuality. In M. Maynard & J. Purvis (Eds.), *Researching women's lives from a feminist perspective*. New York, NY: Taylor & Francis Group.

Howson, R. (2006). *Challenging hegemonic masculinity*. New York, NY: Routledge.

Labov, W., & Waletsky, J. (1997). Narrative analysis: Oral versions of personal experience. *Journal of Narrative and Life History*, *7*(1–4), 12–44.

Lee, C., & Owens, R. G. (2002). *The psychology of men's health*. Philadelphia, PA: Open University Press.

Li, J., Stroebe, M., Chan, C. L., & Chow, A. Y. (2012). Guilt in bereavement: A review and conceptual framework. *Death Studies*, *38*(3), 156–171.

Lyons, A. C. (2009). Masculinities, feminities, behaviour and health. *Social and Personality Psychology Compass*, *3*, 394–412.

MacKenzie, S., Wiegel, J. R., Mundt, M., Brown, D., Saewyc, E., Heiligenstein, E., & … Fleming, M. (2011). Depression and suicide ideation among students accessing campus health care. *American Orthpsychiatric Association*, *81*(1), 101–107.

Mahalik, J., Burns, S. M., & Sysdek, M. (2007). Masculinity and perceived normative health behaviours as predictors of men's health behaviours. *Social Science and Medicine*, *64*, 2201–2209.

Möller-Leimkuhler, A. M. (2003). The gender gap in suicide and premature death or: Why are men so vulnerable? *European Archives of Psychiatry & Clinical Neuroscience*, *74*(1), 70–75.

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic*, *30*(1), 133–54.

Oliffe, J. L., Kelly, M. T., Bottorff, J. L., Johnson, J. L., & Wong, S. T. (2011). "He's more typically female because he's not afraid to cry": Connecting heterosexual and gender relations and men's depression. *Social Science and Medicine*, *73*, 775–782.

Oliffe, J. L., Ogrodniczuk, J. S., Bottorff, J. L., Johnson, J. L., & Hoyak, K. (2012). "You feel like you can't live anymore": Suicide from the perspectives of Canadian men who experience depression. *Social Science and Medicine*, *74*(4), 506–514.

Oliffe, J. L., & Phillips, M. (2008). Depression, men and masculinities: A review and recommendations. *Journal of Men's Health*, *5*(3), 194–202.

Parker, K., & Wang, W. (2013). *Modern parenthood: Roles of moms and dads converge as they balance work and family*. Retrieved from http://www.pewsocialtrends.org/2013/03/14/modern-parenthood-roles-of-moms-and-dads-converge-as-they-balance-work-and-family/

Payne, S., Swami, V., & Stanistreet, D. (2008). The social construction of gender and its influence on suicide: A review of the literature. *Journal of Men's Health*, *5*(1), 23–35.

Reismann, C. K. (1993). *Narrative analysis*. London: Sage Publications.

Robertson, S. (2007). *Understanding men and health: Masculinities, identity and well-being*. Berkshire: Open University Press/McGraw-Hill.

Robinson, M., Raine, G., Robertson, S., Steen, M., & Day, R. (2015). Peer support as resilience building with men. *Journal of Public Mental Health*, *14*(4), 196–204.

Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. *Journal of Nursing Scholarship*, *23*, 161–166.

Sandovsky, R. (2005). Men's healthcare needs improvement: A recommendation for a midlife men's health assessment visit. *The Journal of Men's Health and Gender*, *2*(3), 375–382.

Schippers, M. (2007). Recovering the feminine other: Masculinity, femininity, and gender hegemony. *Theory and Society*, *36*, 85–102.

Schofield, T., & Connell, R. (2000). Understanding men's health and illness: A gender-relations approach to policy, research, and practice. *Journal of American College Health*, *48*(6), 247–256.

Seebohm, P., Munn-Giddings, C., & Brewer, P. (2010). What's in a name? A discussion paper on the labels and location of self-organising community groups with particular reference to mental health and black groups. *Mental Health and Social Inclusion*, *14*(3), 392–401.

Sharpe, S. (2002). Attitudes and beliefs of men and their health. *Men's Health Journal*, *1*(4), 118–120.

Smith, J., & Braunack-Mayer, A. (2006). What do we know about men's help-seeking and health service use? *Medical Journal of Australia*, *184*(2), 81–83.

Statistics Canada. (2002). *Leading causes of death, total population, by age group and sex, Canada, annual: Table 102-0561 in Statistics Canada* [database online]. Retrieved from http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1020561

Väänänen, A., Kevin, M. W., Ala-Mursula, L., Pentti, J., Kivimäki, M., & Vahtera, J. (2004). The double burden of and negative spillover between paid and domestic work: Associations with health among men and women. *Women and Health*, *40*(3), 1–18.

West, C., & Zimmerman, D. (1987). Doing gender. *Gender and Society*, *1*(2), 125–151.

Westmaas, J., Wild, T., & Ferrence, R. (2002). Effects of gender in social control of smoking cessation. *Health Psychology*, *21*(4), 368–376.

Westwood, M., McLean, H., & Cave, D. (2010). Coming home: A group-based approach for assisting military veterans in transition. *The Journal for Specialists in Group Work*, *35*(1), 44–68.

World Health Organization. (2005). *The health for all policy framework for the WHO European region: 2005 update*. Copenhagen. WHO. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0008/98387/E87861.pdf