ALCOHOL RESEARCH UK

Alcohol Stories: a lifecourse perspective on self-harm, suicide and alcohol use among men

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EXECUTIVE SUMMARY

This pilot study aimed to test the utility of using life story methods to generate qualitative data among a group of men who had experienced self-harm or suicidal thoughts or actions, exploring accounts of alcohol use across the lifecourse.

10 men took part in an in-depth interview, addressing their 'life story', and focusing particularly on their use of alcohol and experiences of mental ill-health.

Men provided diverse accounts of their use of alcohol and the extent to which they related this to their mental health problems, self-harm or suicide.

Alcohol use was framed as a 'normal' and common-sense response to distress, particularly for men. At the same time, participants emphasised that alcohol was an ineffective, and sometimes counter-productive response to mental ill-health.

At the same time, becoming abstinent from alcohol was associated with isolation, and not all men felt that abstinence was possible or necessary.

Accounts of the relationship between alcohol use, self-harm and suicide highlighted the importance of alcohol in planning 'successful' suicides. For some men, alcohol use was associated with overdoses. Several men reported engaging in self-injury, and this was not framed as 'suicidal', whereas overdoses tended to be described as oriented towards ending life.

Men reported antagonistic or unhelpful relationships with health services. For some men this was related to their perceived 'aggressiveness', for others, it was related to the difficulty services appeared to have in responding to distress in men who were also substance dependent.

These indicative findings, and success in recruiting and engaging a group of 'hard to reach' men, suggest that further qualitative work addressing the complexities of alcohol use, self-harm and suicide is warranted and feasible.

Introduction

Compared to women, men are at greater risk of both suicide and alcohol related harm (Coope et al., 2014). Each of these behaviours is common in mid-life (aged 35-54). Existing research suggests the relationship between alcohol use, mental ill-health and suicide is significant, but complex (Sher, 2006). However, there is limited interview-based research with men about how they understand the relationships between alcohol use and mental health.

This pilot study used life-story methods to investigate the way in which alcohol use was talked about by a group of men who had experienced self-harm, suicidal thoughts or actions. The approach taken acknowledges that alcohol is deeply embedded in British (and especially Scottish) culture, and may have positive, negative and ambiguous meanings for men (Emslie et al., 2013; Robertson, 2007).

Findings from the project indicate that further investigation of the complex and diverse ways in which alcohol is used and understood, particularly in the context of mental ill-health, is warranted. While this was a small sample, common themes were identified: use of alcohol 'to cope'; use of alcohol as part of planning suicide; pubs and social drinking as important – but deeply ambivalent – sites of acceptable sociability for men. Future research should address understandings among women, and non-binary gender people, as well as among men.

Background

Existing research suggests that alcohol use may complicate and contribute to poor mental health, self-harm and suicide (Adams & Overholser, 1992; Chandler, 2012a; Mok et al., 2012; Oliffe et al., 2012). A report published by Samaritans (on which AC was co-author), suggested that alcohol use might be particularly relevant to explaining the high suicide rate found among men in mid-life, from lower socio-economic backgrounds (Chandler, 2012a; Wyllie et al., 2012); and studies have indicated that variations in suicide rates between countries may relate in part to differing rates of alcohol use (Mok *et al*., 2012). Suicide, mental health and alcohol use are complex issues, affected by multiple social, economic, cultural, biological and genetic factors (Sher, 2006). Indeed, Canetto suggests that substance use itself might be a form of 'slow suicide' (1991). Research should reflect this complexity. However, qualitative research that addresses the multifaceted interactions between social context, biography, alcohol use, mental health, self-harm and suicide has been limited; though a limited number of studies have addressed the social complexity of men's heavy drinking (Orford et al., 2009; Tilki, 2006).

Qualitative research with younger men in Ireland and older men in Canada who had experienced suicidal distress and depression respectively found that many reported using alcohol to self-medicate (Cleary, 2012; Oliffe et al., 2012). Studies addressing alcohol use among those in mid-life have found that men attach both positive and negative meanings to alcohol use (Dolan, 2011; Emslie et al., 2013; Orford et al., 2009; Robertson, 2007). Significantly, alcohol is framed by some as helping to support positive mental health by enabling close, supportive and sharing relationships with other men (Emslie *et al*., 2013). *Alcohol Stories* explicitly examined accounts about the relationship between alcohol use and mental health among a group of men in Scotland, who were in mid-life (38-61) and who had

experienced self-harm (with or without suicidal intent). The study complements earlier studies by: a) looking at an older group of men who had self-harmed (in contrast to Cleary 2012 who interviewed younger men); b) focusing explicitly on accounts of alcohol use and mental health (in contrast to e.g. Dolan, 2011; Emslie *et al*., 2013 where alcohol use and mental health emerged in findings, but were not the direct focus of enquiry; see also Oliffe *et al*., 2012).

Methods

Aims and Research Questions

The aims of the project were:

1. To test the feasibility of the adapted *Alcohol Stories* life-grid with a group of men in mid-life who have experienced self-harm and suicidal distress.
2. To generate rich, qualitative data with an under-researched group of men.
3. To explore links between alcohol use and mental health in the accounts of men in mid-life who have experienced self-harm.

Related research questions were:

1. How, and in what ways, do men talk about alcohol use in relation to their life history?
2. How, and in what ways, do men talk about alcohol use in relation to mental health, self-harm and suicide?
3. Is the life-grid an appropriate research tool to investigate these issues?

Recruitment and Sampling

This was an exploratory pilot study, which aimed to recruit 10 men who had experienced self-harm and/or suicidal thoughts or actions. The sample was focused on a particular geographical area (semi-rural, in Scotland), and included men engaged with one of two community mental health services. One of these provided specialist services for people experiencing problems related to substance use, the other was dedicated to men who had experienced self-harm and suicidal thoughts. The sample of men were chosen in order to explore the research questions among a group of men who had experience of self-harm and suicidal thoughts, but who did not necessarily have identified/treated problems with alcohol use. The inclusion criteria were as follows:

a) Male
b) Aged between 35 and 55
c) Experience of or thoughts of self-harm (this includes a range of practices which may, or may not, be understood as suicidal).

AC worked with the mental health services to ensure a reasonably balanced sample, which included men who were receiving treatment for substance misuse, and those who were not. Participants were recruited by workers with the community mental health services. Potential participants were introduced to the study, given a short leaflet (Appendix 1) explaining what the study was about, and asked whether they were interested in taking part. All men were offered a £20 gift voucher as a token of thanks for giving their time and efforts for the research project.

Those who were interested in taking part were offered an informal meeting with AC, the lead researcher. In practice, all of those who took part preferred to go ahead with the interview on first meeting. Due to the efforts of the community mental health workers supporting the project, recruitment progressed steadily, and a sample of 10 was achieved fairly swiftly. A larger sample could easily have been generated. Workers reported that men involved in both services were interested in the project, and keen to help out with an attempt to understand their lives. The relative ease with which recruitment progressed indicates that men experiencing these problems are not *necessarily* 'hard to reach'.

Data collection

One of the aims of the project was to test the use of a life-grid to help structure life-story interviews. The life-grid had been used previously by AC in life-story research with adults who had a history of self-harm (Chandler, 2012b; Chandler, 2013). AC adapted the life-grid to include a section on 'alcohol and me' (Appendix 2).

All interviews were conducted by AC, and took place at offices or quiet rooms at the community mental health service that the participants attended. As such, participants were comfortable and familiar with their surroundings. Further, it is likely that the context of the interviews made it easier for men to talk, since they were all reasonably used to visiting the service for the purpose of counselling or meetings with workers. Interviews lasted between 1 and 2.5 hours, with most lasting 1.5 hours.

As far as possible, the interviews were led by participants. Aside from the presence of the life grid, and participants' awareness about the focus of the research (alcohol, mental health, self-harm and suicide), there was no structure to the interviews, and no set questions. Participants were asked to talk about their life, to start wherever they preferred, and to use the life grid in whatever way they liked.

Ethics

The research was approved by the University of Edinburgh's Centre for Population Health Research Ethics Committee.

All participants gave informed, written consent (Appendix 3). Before beginning the interview, AC went through the research information leaflet verbally, to ensure that participants were aware of the risks and benefits of taking part, assured of their right to cease involvement in the study at any time, and had opportunities to ask questions about the project.

AC worked closely with the mental health workers who supported recruitment, to ensure that participants were as comfortable as possible with taking part. AC met with one potential participant on two occasions, and each time a decision was reached not to go ahead with an interview. At all times, AC deferred to the wishes of participants, and worked to ensure their interests and needs were paramount.

Analysis

Following each interview, AC wrote detailed reflections and field notes. This included reflections on non-verbal aspects of the interview, the emotional tone of the interview, the relationship between AC and the participant, and the way in which the life-grid had been used. All interviews were recorded and transcribed verbatim by a professional transcription service. Transcripts were checked for accuracy, read, and re-read.

BN supported analysis, and both AC and BN read transcripts numerous times. BN drafted narrative summaries of each interview. AC considered these summaries alongside her own notes when constructing sketches of each participant's story. BN carried out initial thematic coding on all transcripts, AC and BN worked collaboratively on developing and refining these initial themes.

Findings

Sample

The final sample included ten men, aged 38 to 61. One of the first participants to be referred by the substance misuse service was slightly older than the inclusion criteria, but given anticipated difficulty in recruitment, was included in the study. All participants reported a history of self-harmand/ or suicidal thoughts. Some men had a history of substance misuse, others described using alcohol heavily, but had not identified this as problematic, and some did not identify alcohol use as ever being a problem. Table 1 provides an overview of the sample, and their reported involvement in alcohol use, self-harm and suicidal thoughts. In determining participants' use of alcohol and self-harm, the table is guided by their own accounts.

Insert Table 1 here

At the time of the interview, all but two participants were not working in paid employment, and reported receiving Employment Support Allowance. Worry about money, tensions over balancing health with paid employment, and anxieties about employment status were a recurrent theme in the interviews.

Most participants reported leaving school with few or no qualifications; three participants described gaining graduate level qualifications. All had previously been in employment in a range of jobs. Work described included the following: mining; armed forces; labouring/building trades; driving jobs; social work; factory work; office work.

Six participants described themselves as single at the time of the interview. All but two participants had children, and most described themselves as involved in their children's lives. However for five participants who had separated from the mother of their children, contact was framed as fraught and difficult. One participant described himself as estranged from his adult children.

Themes

Due to the open, fairly unstructured nature of the interview, the themes that could be drawn out of the accounts men provided were wide-ranging. For the purposes of this report, we focus mainly on those themes relating to alcohol use and the research questions.

Alcohol use, culture and lifecourse

For most participants, alcohol use was described as a normal part of growing up. When asked to talk about when they first tried alcohol, a typical account discussed drinking with friends aged 14, 15 or 16.

> *"Well I had…we used to go [out on a night] and have a drink or two. And we used to go with her pals and we used to go to the [pub] and get a carry out. It was Newcastle Browns. And you used to get a carry out in a bag. Go down to the River [name], go under the bridge, right, [inaudible 33:00] and you're all…and go to the disco. So that was the first of it. But that was only once in a while. [AC: Yeah. And that was when you were about 16?] Uhm-hmm. I never really bothered about drink"* ***Oliver***

Oliver described going on to have significant problems with drinking, but suggested that this did not emerge as a problem until his late 30s, around the time he was diagnosed with a serious mental health problem. Prior to this he "*never really bothered about drink*". The accounts of others who described problem drinking more often indicated that teenaged drinking had segued into continued heavy drinking during their 20s and 30s.

For instance, alcohol was framed as a 'problem' throughout Niall's adult life. He left home at an early age – in large part, he said, to escape from a 'brutal' father, and ultimately joined the armed forces. Alcohol was an integral part of army life, and this allowed Niall to continue drinking 'heavy'.

> *"All your free time you were in the pub and you just drunk and drunk and drunk and in the end, I had to go and dry out twice, because of it. And it's...it's no good"* ***Niall***

Thus, although alcohol use was framed as a 'normal' part of life for many participants, the way in which alcohol weaved its way through the life stories they told differed. Several participants were clear that alcohol use was normal and unproblematic; others emphasised that early on their use of alcohol had been oriented towards 'coping' with troubling experiences. For instance, in contrast to Oliver's description of carefree, exuberant drinking – Brad suggested even at the age of 14 he was drinking in response to problems at home and difficulty dealing with this:

> *"But I don't know why they [friends] drank, like, but I know why I was drinking, like, just to take me away from all the crap, you know, the crap lives that we were living through, and that"* ***Brad***

Similarly, Stevie described the same kind of teenaged drinking, but talked of using it for 'Dutch courage' and a 'confidence boost' which – at least initially – he could manage relatively un-problematically.

> *"Like most teenagers in my neighbourhood we would probably have a drink maybe once a weekend from the age of about 15. And at the time I was 17, 18, we were going out at weekends, me and my pals, but the alcohol wasn't an issue then. I was able to handle my drink; I just drank to a certain point and then stopped. It was really Dutch courage more than anything else and boost your confidence, and it's that knowing when to stop, that's the difference between having a drink problem and not"* ***Stevie***

Participants often spoke of parental drinking, though this emerged in somewhat unexpected ways. Thus, while several participants – including Niall – noted that either their mother or father had been a 'heavy' drinker, others – including Oliver – described parents who did not drink at all.

Tom referred to a geographically specific 'culture' of drinking, which he had become caught up with during his 20s. Like Brad, his wider account suggested that he had engaged wholeheartedly in this lifestyle as a way of 'blocking out' family problems:

> *"But because it's a Scottish mentality, isn't it, we didn't just drink to have a good time. We drank as much as we could as fast as we could just to prove a point or whatever"* ***Tom***

Tom's account framed this 'Scottish mentality' as particularly tied to expressions of violent masculinity that – for him – became 'normality'; a normality which was another method through which he could mask feelings of vulnerability:

> *"That was the thing; it had become a way of life for me. So if I woke up in the morning and I had a black eye, in bed with a lassie and my clothes ripped and stuff like that, I thought that was a great night. And that's the way it became, it was normality"* ***Tom***

For a minority, alcohol was rarely, if ever, described as 'problematic'. Robert and Martin both reflected on why they had *not* 'turned to' alcohol, given their mental health problems. Additionally, although Mike described drinking heavily during his 20s, and indicated that this was a huge part of his life; he was clear that this had been – generally – a positive time in his life: "*…in the drunken days and that, so I just felt I had a great time then*".

Alcohol, emotions and mental health

Alcohol use was described as closely tied to experiences of mental ill-health by participants. A number of themes emerged: a) use of alcohol to mask or divert attention from mental health problems; b) use of alcohol to 'cope' – as an obvious response to distress; c) ineffectiveness of alcohol use as a response to mental ill-health.

A key argument in existing research regarding masculinities and alcohol use is that alcohol is used by men to 'cope with' mental health problems (Cleary, 2012; Oliffe et al., 2012). This theme was clearly present in some of the interviews. As discussed above, alcohol use was framed as a prominent feature across Niall's life story.

> *"Bodies, everything. And after it, nobody helped you. All the officers just patted themselves on the back and all these guys…you were just…nobody helped. So I turned to the drink"* ***Niall***

Here, Niall addresses a particularly traumatic period of time in his career in the armed forces, where he was face to face with a huge amount of death. His account suggests that the help and support available was limited – 'nobody helped. So I turned to the drink'. It is essential to maintain a broad view of the position of alcohol in individual lives when interpreting claims about the use of alcohol to 'cope'. At this point, Niall had already been drinking heavily for some 15 years, and had one period of institutionalised 'drying out'. Niall's use of alcohol to cope with the trauma he faced needs to be understood in terms of a number of contributory factors: the apparent/perceived lack of emotional support in his job; the traumatic nature of the work; masculine ideals about 'coping' and not seeking help; along with his own pre-existing experience of using alcohol to cope.

Stevie presented a similarly complex account of the relationship between his use of alcohol and experiences of mental ill-health. He traced feelings of anxiety and depression back to childhood, and suggested he had begun drinking in his teens in part as a way of masking these feelings. Tellingly, Stevie maintained that he tried hard across his teens and 20s to hide his mental ill-health from friends and family, noting that being seen as having a 'problem' with alcohol was preferable:

> ***Stevie****: "I would still always hide how I was feeling from them. That was purely because I didn't want to worry them. But I was obviously worrying them with the drinking.*
> ***AC****: Was it, I don't know, easier to worry them about drinking than how you were feeling?*
> ***Stevie****: Aye. […] the doctor had said to my parents, tried to tell them the tell-tale signs when I was feeling depressed. And he says watch for him sleeping during the day and not taking care of his appearance and washing and shaving and things like that. So every time I wouldn't have a wash or a shave they would automatically think there's something up. So even when I was feeling depressed, the bottom of the bottom black hole, I would still make sure I got up and I'd wash and shave, I'd change my clothes just so they didn't know. So they always thought everything was fine"*

Stevie's account suggested a long period of time where he attempted to hide feelings of depression and anxiety, blaming any potentially telling signs (such as staying in bed all day) on physical health problems, or his use of alcohol. In existing literature, such practices are tied to ideals about 'masculinity' and mental health, and the idea that men should not show signs of (emotional) weakness (Oliffe & Phillips, 2008).

Tom's account also suggested a long period of time from his late teens to his early 30s where he used alcohol and drugs, and immersion in a life of violence and criminality in order to avoid reflecting on other problems with his family life.

> *"That's when I started drinking, violence, because I'd obviously been through all this traumatic experience for a couple of years, and then I used to say I was fine. Yeah, I'm alright. Everybody else knew I wasn't. And then I'd drink and then I'd just lash out. So it certainly went part and parcel because I'd created a false self to survive"* ***Tom***

Alcohol use was framed by many participants as an 'obvious' response to feelings of depression or stress:

> *"I was working and that, but I felt really depressed. And I thought, I shouldn't be depressed. I've got a wife, got a house, got a family. I'm doing alright. But then you get that depressed, you're having a drink"* ***Oliver***

> *"And I remember having a kind of, dealing with that kind of stress by using drink"* ***Martin***

For some men, this was a temporary 'crutch'. Martin, for instance, suggested that he consciously pulled back from using alcohol to deal with 'stress', since he could see himself developing a problem with it: "*But also, there's also something in there, that I could have been easily an alcoholic, I could have went down that route, without a doubt...".*

While using alcohol to cope with or mask emotional distress was common; so too were accounts which highlighted the ultimately futile nature of attempting to use alcohol in this manner:

> *"I think what it is, it's [a scapegoat]. It blocks it out, but only ever temporary, because when you've come to whatever pub you go, it's still there and it'll not go away"* ***Oliver***

> *"And that's what people do; let's have a drink to deal with it. You're not dealing with anything; you're avoid things. Deal with it head on, don't throw substances into the equation because it's only going to make things worse. You'll beat yourself up and the problem's still there"* ***Tom***

> *"So it's like a vicious circle; you're depressed and then you drink, and when you're drunk you get even more depressed kind of thing. And what first started is having a drink to help you cope just made things worse after that"****. Stevie***

There was certainly an awareness among participants that while they accounted for alcohol use in terms of 'coping' with problems, that this was 'temporary' – problems did not go away, or as Tom and Stevie noted, alcohol use could make them worse. The relationship between alcohol use and the exacerbation of personal or mental health problems was raised by many participants. Thus, for those participants who described themselves as either abstinent or

attempting to maintain abstinence, there was an understanding that alcohol use escalated the problems it might have been initially used to 'deal with'.

> *"But I certainly would never add fuel to the fire again. It's bad enough dealing with what you've got without making it worse"* ***Stevie***

However, the ability to name the futility of alcohol use was not necessarily associated with describing no problems with alcohol use. For instance, both Oliver and Niall addressed this issue, but both described on-going problems with alcohol – finding it hard to avoid drink, and finding it hard to drink in moderation. In both cases, this was discursively related to a number of complex factors, but loneliness and boredom featured prominently.

> *"I've got to really get out every day, because it's monotonous if you're sitting in the house. Do all your housework, the washing and that, but you're sitting looking round four walls. And if you're drinking cider…and for some reason I end up on the vodka"* ***Oliver***

In contrast, other participants appeared to have been able to move away from using alcohol to 'cope'. At the time of the interview, Stevie described himself as being abstinent for 15 years, after spending around 10 years drinking heavily. Stevie's account framed alcohol as something he used to mask pre-existing issues with low self-confidence and anxiety.

> *"Since it's about alcohol, for me personally, I think I used alcohol as a crutch, trying… I've never been a very confident person, so I used alcohol for confidence rather than anything else, but then it got out of hand probably from… I haven't had a drink for 15 years"* ***Stevie***

Stevie's account was reasonably distinct among the sample, in that he described a warm and supportive family. Thus, although he had ongoing struggles with depression and anxiety, loneliness and boredom were less evident in his account. Further, he described a firm commitment to sobriety which differed from the more tentative hopes for sobriety articulated by Niall.

> *"[AC asks if it is harder to avoid drink when N is depressed] Without a doubt. Without a doubt. And especially, like, the run up to Christmas, things like that. They're all depressing. And it's hard. And you just drink…it's not...I…it's not 'cause you want to have a drink, it's just 'cause you're lonely sometimes and depressed and…that's what it…that's what I do. Yeah"* ***Niall***

Mike, Martin and Robert indicated that alcohol use had never been a significant 'problem', though were still able to talk about cultural understandings which tied alcohol use to 'coping'. In each case, given the focus of the research interview, the men attempted to reflect on this, suggesting that alcohol 'could' have become a problem for them. Each appeared at a loss to explain why. Martin indicated this was a conscious choice on his part. Mike, on the other hand, talked of drinking heavily for many years, and framed this reasonably positively. He reported stopping drinking easily following a diagnosis of a physical illness which was exacerbated by drinking.

Accounts of using alcohol in response to emotional distress were common and reflect the existence of more widely circulating cultural narratives which advocate this. At the same time, participants also reproduced a clear counter-narrative, referring to the ineffectiveness of using alcohol in this way. Existing research has suggested that men may be more likely to 'turn to' alcohol in the face of emotional distress (Creighton et al., 2016), and there was some evidence in the sample that alcohol was framed as clearly preferable to 'admitting' problems to others. This was particularly evident in the accounts of Stevie and Tom.

Alcohol use, suicide and self-harm

Participants related alcohol to suicide and self-harm in several discrete ways. Alcohol was associated with suicide planning as well as with more practices of self-harm, both overdoses and cutting.

In some accounts, alcohol-use emerged as an important part of suicide planning, and a reason why others could 'successfully' complete suicide: alcohol provided needed courage when planning or carrying out a suicide.

> *"…there will be people who, ken, directly link things like drink and suicide and they might feel suicidal, they've been drinking. And if they hadn't been drinking, they wouldn't have done it. But that's maybe, but my opinion on that is that they may have been suicidal and then had the drink and it's just given the courage to do it"* ***Mike***

Mike's account addressed wider cultural narratives regarding the relationship between suicide and cowardice or courage. For Mike, suicide was something that took courage – and alcohol, he suggested, might be part of how others were able to 'go through with it'.

Robert was distinct from the other men in the sample in framing himself as someone who had rarely used alcohol. However, Robert did indicate that alcohol had been an aspect of earlier suicide planning. He talked in detail of plans he had made to complete suicide, and – like Mike – suggested that alcohol use could be a part of 'going through with it'.

> *"There are ways of doing it. It's the doing it that's the problem. It's the getting yourself to that point of doing it. And alcohol would certainly help"* ***Robert***

While Robert suggested he still struggled with ongoing suicide ideation, at the time of the interview he maintained he was committed to staying alive, and had 'forgotten' about the bottle of spirits he had bought as part of an earlier suicide plan. Importantly, both Mike and Robert identify alcohol as being a culturally understandable method of enhancing the 'courage' needed to go through with a suicidal act (Conner et al., 2007).

For other participants, alcohol use was directly implicated in suicidal and non-suicidal self-harm. Paul talked of cutting himself when drunk during his 'drinking years'; and maintained he could not cut himself sober as it 'hurt too much'.

> *"I'm glad to say, when I cut, always it would just be when I drank […] Tried it a few times when I was sober, but it hurt too much. I wouldn't bother, and I think…this…not this year, it's only February, last year, I did cut myself a wee bit just to see [shows mark], and annoyingly I had to…yeah, it's alright. If I get that angry I'm, yeah, tempted again, but then I thought, no, I think I need a drink in me, so that's kind of…I would say it's went away, so it was really on and off"* ***Paul***

Oliver spoke of a close friend who had frequently cut himself when drunk. Oliver's account suggested a fairly chaotic time when he and his friend had drunk heavily and both been regularly admitted to A&E following self-harm.

> *"The alcohol…my pal, he was…I think he was bipolar as well, because every time he had a drink, he was very suicidal, but what he used to do was cut his wrists… [AC - Did he? Did he? Oh that must have been hard] Oh aye. I used to find him. Blood all over the…oh fuck. Go through and here's him lying with wrists all cut. Phone an ambulance and all, but he was very suicidal. All the time he used to cut his wrists when he had a drink and all that"* ***Oliver***

It is important to highlight that the types of self-harm that participants described were very different. Stevie, for instance, spoke of injuring himself in order to feel pain – suggesting that this may have helped him to manage anxiety states, to 'ground' himself. Paul implicated self-injury in terms of feelings of anger, noting that ongoing 'anger' led him to consider injuring himself currently. Brad suggested he was unsure what had driven his teenaged self-cutting, but reflected that while he had 'stopped' cutting himself, he found other ways to hurt himself:

> *"I still don't understand, to this day, why I did that. I mean, I did that, the cutting thing, I did that from being about, from about 14 year old, up to about 19, 20, yeah […] And then, I stopped after that. Never, ever done it again, like […] I used to find new ways to go and hurt myself, then […] Go and pick a fight with somebody bigger than you"* ***Brad***

Several participants described taking overdoses when drinking; mostly referring to incidents that had occurred when they were in their 20s. Both Mike and Brad described overdoses following break ups; while Stevie, Paul and Oliver described overdosing when drinking, Oliver indicating this had been a routine occurrence during his 40s.

A complex picture emerged from these ten accounts of the ways in which alcohol use intersected with self-harm and suicide. Alcohol use was discursively tied to suicide attempts in terms of talk about planning; and accounts of overdoses in the context of alcohol use. At the same time, some participants emphasised that their practice of self-harm – or their mental health problems in general – had preceded their use of alcohol.

Managing or stopping alcohol use

Most participants described attempting, or managing, to control alcohol use, either through abstinence or reduction. A common way in which men talked of 'stopping' alcohol use, was following a 'turning point' event: a physical illness or injury or – more rarely – an interpersonal event which caused them to alter (usually stop) their drinking (Teruya & Hser, 2010).

Mike, Tom, Paul and Stevie each described themselves as abstinent following earlier periods of their life where they had drunk excessively. Though Mike's account framed his alcohol use as largely 'positive', he was nonetheless clear that his drinking had been all encompassing, taking up the majority of his free time and money.

> *I was making quite a lot of money at the time as well, so I had a lot of money to drink. And that's where it all went I'm afraid, on the drink. And so I was there [at the pub] every night. And at the weekends, I'd just drink…it was all I did"* ***Mike***

Mike and Tom described developing serious health problems in their late twenties, after which they were advised not to drink. In Mike's case this led to him maintaining abstinence for the following twenty years. Mike had a house, a steady job and a wife at this time, and although he described living with depression and suicidal thoughts across this period of time, he indicated he had been able to give up drinking with no difficulty.

In contrast, Tom reported switching to drug use (primarily cannabis). Tom's personal circumstances were quite different from Mike's: he described a 'chaotic' life, where he was involved in violent crime, drug dealing, multiple sexual relationships and homelessness. There were clear differences then in the wider context of Mike and Tom's lives, which may partially explain their different responses to 'doctor's orders'.

Oliver and Niall both described ongoing 'struggles' with their alcohol use. Each indicated that they had a 'problem' with alcohol, and both also suggested that they did not maintain complete abstinence. For Niall, this appeared to be something that occurred infrequently – once every few months; whereas Oliver described drinking heavily once a week. The way in which Oliver and Niall described their alcohol use was different. For Niall, avoiding alcohol was a 'battle', and he indicated that a lot of work was put into occupying himself, and arranging his routines to ensure his sobriety. In contrast, Oliver's account indicated less of a 'battle' – he appeared – reasonably – content with drinking heavily once a week; highlighting that this was a vast improvement on his earlier drinking which had involved binges that lasted several days.

Other participants provided accounts of continuing to drink alcohol, but in non-problematic ways. Brad framed himself as now 'in control' of what he drank and when.

> *"But I'm not letting it, at the minute. I mean, I do drink, I'm not saying, like, I will drink, and I'm not gonna lie to anybody and say, no I'll never drink again, like. Of course I will, I know I will. But I've got a lot more control over it nowadays"* ***Brad***

Brad demonstrated this control by noting that he kept bottles of spirits and wine at home, but mostly did not drink them, until – occasionally – he 'felt like it'.

Martin talked about choosing not to drink, also framing this in terms of control. In his account he reflected on why he had not 'chosen' to continue drinking; framing his story very much in terms of self-determination:

> *"A choice to take it or leave it. And I chose to leave it, because that's the only thing I could control. I could make matters worse, I know I could have dampened it. And I realise at the early part of it, I dampened my...when I as drinking three or four cans a night, it was taking away, it was numbing me, it was taking away...I was wanting to die, I was wanting to go to sleep and not wake up, and that. I was praying for to go to sleep and not wake up, please don't. And I realised that, in the morning, when I was sober, the pain was there again"* ***Martin***

Those participants who related having 'problems' with alcohol often talked of the difficulties they faced in maintaining abstinence given the ubiquity of alcohol use in everyday social life. For Paul going to pubs remained part of his life, and he reported being able to go into these spaces and not drink alcohol. At the same time, he indicated discomfort when around others who were 'drunk'. Similar stories were provided by Mike and Stevie. For Mike and Stevie, avoiding places where others would be drinking was important – both framed such situations as difficult – they felt awkward socially; and irritated by others who drank too much. As Paul notes here, this may have been partly related to feelings of guilt associated with reflecting on their own imagined behaviour when they had been drinking:

> *"I was alright 'til about quarter to 12, and then folk were starting to get a bit pished. I thought, I'm going to punch someone, he's just an arse, but that must be what folk do when they're drunk, and I've [inaudible 21:55]. I felt bad about myself, I was like, god, what was I like then? And that's when I sort of said […] look, I've got to go now"* ***Paul***

Isolation and loneliness was a key feature of many of the accounts; and the felt inability to go to pubs was part of this. Particularly for those – such as Mike and Stevie – who had previously spent a lot of time in pubs drinking. Mike was clear that in his earlier years this had been the main way in which he spent his time. Stevie emphasised how the importance of alcohol in the lives of men made it difficult for him to socialise once he had identified he had a 'problem' with alcohol:

> *"And of course when you're growing up, late teens, early 20s, that's all your pals want to do, is go to the pub. By that time I've realised I've had an issue with it and then you can't very well say to them do you mind if we just don't go to the pub or something. You either go or you don't, simple as. I'd rather be on my own sitting in the house than go with them"* ***Stevie***

While Stevie emphasises that he ultimately chose to avoid going out, and avoid alcohol; his account highlights the difficulties that may be faced by younger me experiencing mental ill-health and facing isolation if they 'stop drinking'.

Managing or stopping alcohol use, particularly when it was identified as a 'problem' by either the participants themselves, healthcare professionals, or friends and family, was a challenge. Men's accounts of responding to this challenge varied, and they reported diverse strategies and orientations towards reducing or stopping alcohol use. Control and mastery were emphasised by some; others spoke of avoiding social situations where alcohol would be present; others indicated that they replaced alcohol with other drugs. Others appeared to accept some element of 'slippage' in their ability to maintain abstinence from alcohol.

Men and health services

Participants in this study were all engaged with community based mental health services, and spoke highly of the service they received. However, accounts of interactions with other services were more often negative. Participants spoke of difficulties faced in having their distress recognised or validated by services. Several men emphasised that they avoided or edited accounts of suicidal thoughts or actions, even when asked.

> *"And then at the same time you're frightened […] see when you're at the doctor's and they send you to the psychologist and that, they'll go, how would you do it? Right? Well you can't say, I'd take an overdose, because if you say, I'll take an overdose, they then tell the doctor and have this thing where you can't get your tablets. You have to go down and get them every other day. So you're not going to tell the truth, are you? You're just going to say, oh well, I'd hang myself, or something like that, you know what I mean. Or cut my wrists, or whatever. But you just, like…do you know they're…so things are awkward for people. It's not an easy thing"* ***Mike***

These accounts indicated the difficulty men faced in being 'honest' with services about suicidal thoughts. For Mike, this was tied to worries about his prescription schedule being changed; for others, such as Brad, this was associated with the 'difficulty' of articulating suicidal thoughts to service providers with whom he had an antagonistic relationship: "*I don't want to tell them*". Brad also spoke of the challenges he faced when navigating services as someone who had 'problems' with substance use, as well as ongoing depression. He suggested that for some service providers there was little tolerance for this.

> ***Brad****: Well there you go, my depression. I can't see a psychiatrist, unless I quit smoking dope.*
> ***AC****: Right.*
> ***Brad****: What's that got to do with seeing a f***ing psychiatrist, you know. If I turned round and said that to my GP, you know, just what I just turned round and said to you – 'what's that got to do with seeing a fucking - you know, seeing a f***ing psychiatrist'. I'm being abusive and aggressive - get out, we'll not treat you anymore.* ***Brad***

Brad's account also alluded to the difficulties he faced in trying to access help for mental health problems, and worries about how his behaviour might be perceived by service providers. He refers to a fear of not being treated if he is seen as 'being abusive and aggressive'. Lewis also provided a narrative of seeking help and being thwarted by inflexible services, who then interpreted his distress as 'threatening':

> *"And I said, have you not got ten minutes - no, you'll have to make another appointment, as she's driving away. I said, 'oh well f*** off then'. And she reported me for that. She went back, because I got a letter saying that they were...because of my language, and she felt threatened!"* ***Lewis***

These accounts provide some insight into more widely circulating narratives regarding the lack of fit between mainstream mental health services and 'men' (Wilkins, 2015). Some men's health organisations argue that mental health services are not designed for men, but for women. This is a complex issue: clearly, the behaviour that Brad imagines, and which Lewis reports engaging in, *could* be experienced as threatening. However it is hard to disentangle particular expressions of frustration ("*oh well f*** off then*") from the person uttering them. Men are more likely than women to be viewed as violent and dangerous rather than ill and in need of help (Rogers & Pilgrim, 2010). Additionally, the inflexible responses of service providers in these cases can also be understood as extremely frustrating.

Stevie related another example of thwarted help-seeking, suggesting that this was a result of his use of alcohol prior to trying to re-admit himself to inpatient care:

> *"... there was another time where I'd been really struggling for a few days and I'd been off the drink, I was really, really struggling, and I wanted to sign myself back into [rural psychiatric unit] and to give myself Dutch courage I had a drink, and then when I got up there they didn't accept me because I'd been drinking. So I then had to walk back from [rural psychiatric unit], which is a good nine or ten mile away from where I stay"* ***Stevie***

Though not in the context of alcohol use, Robert also recounted an instance of presenting at a community hospital out of hours, during a mental health 'crisis' only to be turned away. Among this admittedly small sample, a pattern emerged, whereby men described attempting to seek help, but experiencing antagonistic or dismissive responses from providers. This mirrors findings elsewhere regarding the problems faced by those who self-harm when they attempt to seek help (Chandler, in press, 2016).

Use of the life grid and reflections on methods

The life grid garnered mixed results in the interviews. As described above, participants were invited to use the grid in any way they liked, including choosing not to use the grid. One participant chose to write on the grid himself, with the remaining six who chose to use the grid preferred AC to write for them, while they concentrated on talking.

One of the limitations of the life grid is that it forces a linear structure to participants' stories, and this was not always appropriate. At the same time, the structure was reported as being helpful by some participants, when trying to reflect on their lives overall. Indeed, some participants suggested they were uncomfortable with the unstructured nature of the interviews, and indicated a preference of being asked specific questions, rather than setting the agenda themselves. There is clearly a balance to be set, then, between supporting participants to 'tell their story' and also providing guidance when needed.

More broadly, participants were appeared interested in taking part in a project that allowed them to tell stories about their lives, and to have someone unrelated to their care 'listen'. Given the antagonistic relationships with services described by some of the men, my identity as an outsider who was nonetheless 'on their side' was valuable. This also offers important messages to service providers about the way in which they are characterised by men as being 'not on my level' and not able to understand important aspects of their lives.

Implications and conclusions

This was an exploratory study, and as such the above findings are indicative and tentative. Nevertheless, important themes emerged from men's accounts of alcohol use, mental health, self-harm and suicide, and the successful completion of the study is itself a promising outcome. These findings underline the need for further qualitative research which addresses the complex ways in which alcohol use intersects with mental health, and is shaped by gender identities and gendered practices. That recruitment proceeded swiftly and successfully suggests that engaging men in qualitative research about these issues is both possible and valuable.

The life grid may offer one way of conducting such research, but future research should test the use of more diverse, participatory methods through which to engage research participants. The grid may work more successfully if used alongside semi-structured interview questions.

Following the limited existing work with men who had self-harmed (Inckle, 2014; Russell et al., 2010), this study points to the need for further qualitative investigation of the meanings that self-harm – whether 'suicidal' or not – has for men, as well as women. Several participants in this study highlighted that they had not disclosed their practice of self-harm outside of the research interview, which offers support to the theory that male self-harm is particularly under-reported.

Further research

This study has confirmed the utility of generating qualitative data with men who are at risk of suicide, regarding their use of alcohol, and how this might relate to mental health, societal expectations about gender roles and performance, suicidal thoughts and practices of self-harm.

Future research should address the following:

a) Exploring narratives about gender, alcohol use and mental health among larger and more diverse samples, including men, women and non-binary people; and those who are not already engaged with services.
b) Attending to social practices relating to alcohol use, sociability and emotional management. Using ethnographic approaches to examine the way that men and women use alcohol, and the performance of embodied, emotions in the context of alcohol use.
c) Developing longitudinal approaches which address both practices and meanings associated with alcohol use across time; incorporating attention to the role and position of alcohol in social and emotional lives.
d) Work should continue on the integration of/relationship between mental health and drug and alcohol services, particularly with regard to self-harm (Ness et al., 2015). Such work should attend especially to the way in which gender may shape access to and responses from these services.

Outputs

There are a number of completed and planned outputs, in the form of presentations and papers for a range of audiences.

Presentations

Masculinity, emotions and suicide: individual explanations and social problems

Annual Meeting, Society for the Study of Symbolic Interaction in Chicago, August 2015.

Abstract

Men are characterised in health policy and research as being, variously: hard to reach; difficult to engage; reluctant to talk; emotionally inarticulate. Such descriptions are employed in attempts to explain why particular groups of men (in mid-life, white, from poor, post-industrial communities) are at greater risk of suicide than any other demographic group (in the UK). This paper reports findings of a study which held biographical interviews with men in mid-life, attending a community mental health centre in a semi-rural, ex-mining community in Scotland, UK. I compare individual narratives of emotions and mental health with widely circulating cultural stories about masculinity, emotions and suicide.

Analysis of men's accounts of experiencing mental illness complicate dominant stories which circulate in public life regarding masculine emotional reticence. Emotions and emotion-talk were evident in all interviews, with emotional stories told about relationships, employment, health and illness. At the same time, some men pointed to their own emotional reticence when accounting for their mental health problems; speaking of years of (self-imposed) silence. However, others provided accounts which unsettled cultural stories which focus on male 'failure' to disclose emotions or seek help, pointing to the role of uncommunicative intimate relationships and thwarted formal help-seeking.

I suggest that current explanations for male suicide are limited by dominant, gendered discourse about emotions. Cultural stories about masculine emotional reticence constrain the

possibilities and identification of emotion talk among men. The relational contexts in which emotional communication is made possible are too-frequently downplayed, serving to pathologize individual men, rather than acknowledging the silencing relationships and expectations with which they live. Further, a story of male suicide which frames emotions as individual and internal diverts attention from structural inequalities and interpersonal problems which might be understood as contributing to pathological emotions.

Alcohol, self-harm and suicide among men: a qualitative exploration

Scottish Alcohol Research Network/Scottish Health Action on Alcohol Problems, Postgraduate and early-career symposium, 18th April 2016. Edinburgh, Scotland.

Abstract

There is a complex relationship between alcohol use, self-harm, and suicide. It is thought that higher rates of alcohol use among men may partially explain men's greater risk of suicide. Men in mid –life (35-54), from lower socioeconomic backgrounds are at greater risk of alcohol related harm and suicide. There has been limited qualitative engagement with the accounts of men themselves regarding the potential relationship between alcohol use and suicide, despite both having rich social meanings and cultural histories.

This paper reports on a sociological study which piloted the use of life-story methods among a group of men who had experienced self-harm (suicidal, non-suicidal or of uncertain intent). The sample was aged between 38 and 61, and reported diverse experiences with alcohol: three described minimal/no problem drinking; four were abstinent but reported significant problem drinking in their past; three indicated that they were currently drinking in a hazardous manner. Interviews addressed alcohol use across the lifecourse, as well as eliciting talk about wider aspects of men's lives: work, relationships, health, leisure pursuits.

Several dominant narratives emerged in accounts of the relationship between alcohol use and suicide. Alcohol was framed as an important part of planning 'successful' suicides – serving to enhance 'courage'. Alcohol was described as a largely ineffective method of managing isolation, boredom, loneliness, low self-esteem and depression. At the same time, alcohol use was framed as a normal, mundane aspect of Scottish culture – particularly for men. This feature made it hard for those who had identified having a 'problem' with alcohol to balance their health and social life.

Findings from this pilot highlight the importance of attending to the social meanings of alcohol use in attempts to understand self-harm and suicide among men.

Accounts and practices of alcohol use among older men at risk of suicide

Invited paper for: 'Saving lives: Understanding the links between alcohol and suicide', Alcohol Concern Cymru, Swansea, 22nd September 2016

Papers

Four papers are planned. These are designed to ensure findings from the study reach key audiences: a) Drug and Alcohol Studies; b) Suicide Prevention; c) Social Science – medical sociology, symbolic interaction.

- 'Alcohol use, self-harm and suicide among men: a qualitative study' (AC, BN) for e.g. *Drug and Alcohol Dependence*
- 'The role of culture in understanding relationships between alcohol use, suicide and NSSI among older men: the case of Scotland' (AC, BN) for e.g. *Archives of Suicide Research*
- 'Masculinities, alcohol use and mental health across the lifecourse' (AC, BN) for e.g. *Social Science and Medicine*, *Health Sociology Review*
- "The Man in the Mirror": accounts of masculinity and mental health' (BN, AC) for e.g. *Symbolic Interaction*

Additionally, a CRFR Research Briefing will be produced and circulated electronically during Summer 2016. I will also hold an associated seminar at the Centre for Research on Families and Relationships, University of Edinburgh showcasing the project findings.

Future Research

Findings and outputs from this project will inform future research proposals to be developed over Summer 2016.

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