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Suicide: Why Are Older Men So Vulnerable?

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Abstract

Globally, older adults have higher suicide rates than other age-groups. However, it is predominantly men who die of suicide in late adulthood, with variability by culture. In the United States, European-descent men are overrepresented among suicide decedents. In this article, theories and evidence about aging adversities, individual dispositions, and cultural influences were evaluated for their potential to explain the suicide vulnerability of European-descent older men. Aging adversities were not found to account for these men's suicide proneness. European-descent older men are exposed to less severe aging adversities than older women or ethnic-minority men—though they may be more impacted by them. Rigidity in coping and in sense of self, consistent with hegemonic-masculinity scripts, emerged as individual-level clues. The indignities-of-aging and the masculinity-of-suicide scripts may be cultural influences. This analysis shows how consideration of masculinities and suicide scripts expands our understanding of older men's suicide as well as, likely, our tools for its prevention.

Keywords

older adult men, suicide, rigidity, masculinity-of-suicide script, indignities-of-aging suicide script

Older adults have higher suicide rates than younger age individuals in almost all regions of the world. A common explanation is that older adult suicide is a response to the adversities of late adulthood. An early version of this theory was put forth by

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Dublin: "With advancing years ... forced changes become more difficult and disturbing. Impairments are accumulated, particularly of chronic and painful diseases. Many older people suffer from ... feelings of loneliness and futility as relations with family and friends and productive work drop off. Economic insecurity is often a serious problem, as is also inability or unwillingness to tolerate hardship" (1963, 22). Given the many difficult changes that come with advancing years, therefore, "it is not strange [according to Dublin] that some old people wish to shake off the infirmities and the boredom of an unsatisfactory existence" via suicide (p. 7). In recent versions of this theory (e.g., Chiu and Tsoh 2013; Conwell and O'Riley 2013), the typical adversities of aging presumed to challenge the coping capacities of older individuals also include health, social, and occupational/economic problems.

A challenge to the adversities-of-aging theory is the gap in older adult suicide rates by sex. It is predominantly men who die of suicide in late adulthood. World suicide rates (per 100,000) individuals have been estimated at 28.2 for men age sixty to sixty-nine (as compared to 12.4 in their female age peers), 42.2 for men age seventy to seventy-nine (as compared to 18.7 in their female age peers), and 60.1 for men age eighty and older (as compared to 27.8 in their female age peers; Värnik 2012). The male to female ratio for persons aged sixty and older is however variable by region and country—the ratio being higher in high-income countries than in low- and middle-income countries (Shah et al. 2015; World Health Organization 2014).

Another challenge to the theory that suicide is a relatively normal response to the adversities of aging is the within-country variability in older adult rates by sex and ethnicity, and the sometime paradoxical manner of such variability. For example, in the United States, suicide rates are highest among European-descent older men, and lowest among older women of Indigenous- and African descent (Centers for Disease Control and Prevention n.d.). The suicide rates of European American older men are nearly three times higher than the suicide rates of ethnic-minority older men (see Figure 1).

The variability in older adult suicide rates, by sex and culture, means that questions and explanations about older adult suicide need to be sex- and culture grounded (Canetto 1992, 1997; Fung and Chan 2011). This article examines theories and evidence about older adult suicide by sex and ethnicity in a case country, the United States. The suicide vulnerability of older men of European descent is this article's guiding question. Articulating cultural and gender factors in these older men's suicidal behavior is this article's primary goal. Culture and gender analyses of European-descent older men's suicide are nearly absent in the literature.

In this article theory and evidence on contextual factors (i.e., the adversities of aging) in the suicide vulnerability of European-descent older men are considered first. Next, theory and evidence on individual factors are examined. Finally, theory and evidence on cultural factors are discussed. To provide examples of cultural and gender themes in the suicide of older men of European descent, the section before the discussion features the cases of two older European American men who took their lives, and examines how their suicide was narrated and explained in the media of their time.

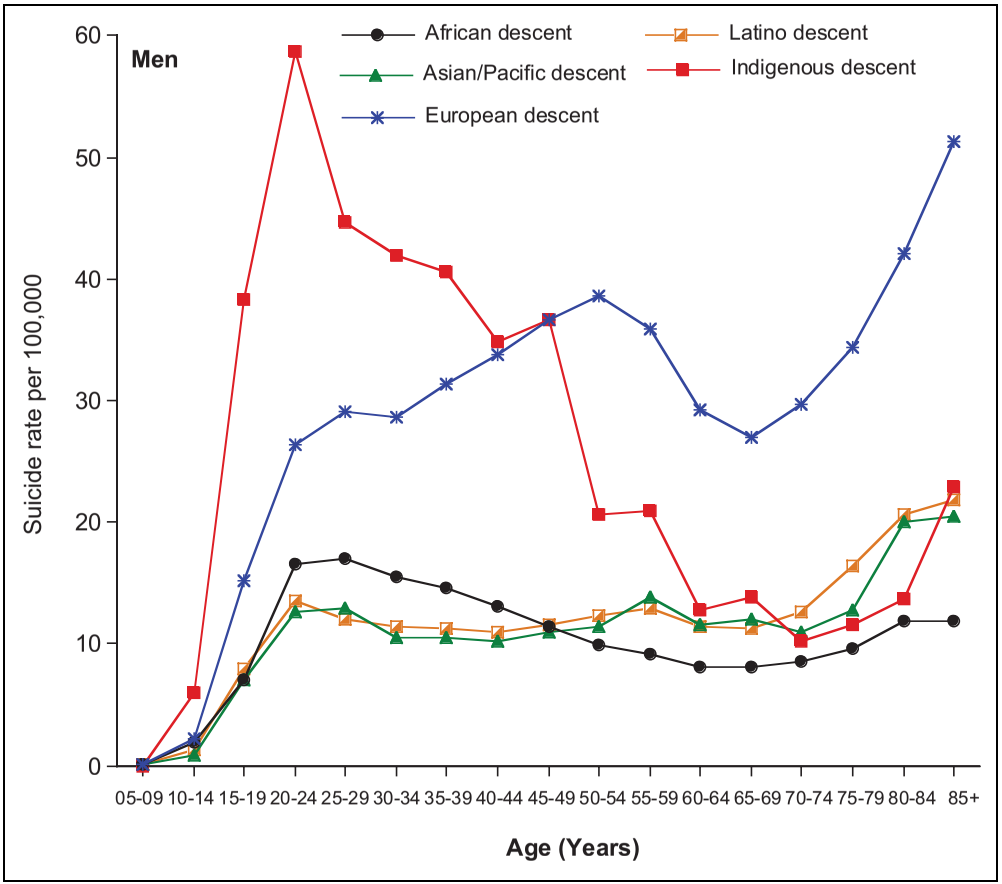

Figure 1. Men's five-year average suicide rates by ethnicity and age, United States, 2009–2013. From the Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS) Fatal Injury Data, http://www.cdc.gov/injury/wisqars/fatal.html. Graphs generated by John L. McIntosh, Indiana University South Bend, March 2015.

Why Are Suicide Rates Highest among Older Men of European Descent? Do the Adversities of Aging Explain Their Vulnerability?

The first issues to consider in trying to explain European-descent older men's high suicide rates are the adversities of aging. The aging adversities most often associated with suicide in the literature are physical health, social, and occupational/economic problems.

Are Suicide Rates Highest among Older Men of European Descent because They Suffer from Worse Physical Health Adversities than Older Women or Ethnic-minority Older Men?

Physical illness has long been theorized to play a role in older adult suicide. "Understanding the association between late-life suicide and physical illness is critical because ill-health may serve as an important stressor contributing to the accumulative risk for a vulnerable individual," argued Conwell and O'Riley (2013, 211). According to a recent review of studies, physical health problems were present in the majority of older people who took their own lives. The conclusion of the review was that certain "physical conditions including malignancies and diseases of the cardiovascular, pulmonary, gastrointestinal, and central nervous system ... [are] implicated" in older adult suicide (Conwell 2014, 245–46). In the review, it was recognized that the base rate of physical illness in older adulthood is high, and therefore its predictive value for suicide is low.

Could physical health problems be an explanation for European-descent older men's high suicide rates? Are these men in worse physical health than older women or ethnic-minority older men? Studies do not find that older men in general, and older men of European descent in particular, have higher rates of physical illness and functional disability than older women (Meyer and Parker 2011). If anything, the opposite is true. Typically, women have morbidity rates that are higher than (or at best, similar to) those of men. The types of illnesses women and men typically experience are different: men are more likely than women to be diagnosed with more immediately life-threatening illnesses, such as cancer, but are less likely than women to suffer from chronic, debilitating (but not immediately life threatening) illnesses, such as arthritis (Bird and Rieker 2008; Hayutin, Dietz, and Mitchell 2010). Also, older men experience lower levels of functional impairment than older women (Cameron et al. 2010). In addition, men are less likely than women to suffer from painful conditions (Bird and Rieker 2008). With regard to ethnic differences, older men of European descent generally enjoy better physical and functional health than ethnic-minority older men—particularly relative to ethnic-minority older men with lower suicide rates (i.e., older men of African descent; Hayutin, Dietz, and Mitchell 2010; Link, Phelan, and Fremont 2000).

Could European-descent older men's high suicide rates be related to their worse access to care, relative to older women or ethnic-minority older men? Once again, the opposite is true. European-descent older men have greater access to medical care than older women or ethnic-minority older men. Older men of European descent also have more resources (e.g., wealth) and are more likely to be able to afford costly medical services than older women (Cameron et al. 2010) or ethnic-minority older men, particularly older men with lower suicide rates (i.e., African- and Native-descent older men; US Department of Health and Human Services 2001). In fact, a national study of community-dwelling older adults found that older men made more physician visits (including preventive care visits) and were more likely to have hospital stays than older women with similar demographic and health profiles, even after adjusting for economic access factors—a finding that was interpreted as related to men's fewer caregiving responsibilities (Cameron et al. 2010). Furthermore, older men have smaller family networks than older women, but they can count on their spouses for care, while older women cannot. When suffering from illness or disabilities, older men are usually cared for by their wives, in contrast to older women who are usually cared for by their daughters or another female relative (Hess 1990; Montgomery and Datwyler 1990; National Alliance for Caregiving and American Association of Retired Persons 2009).

In conclusion, older men have less exposure to, and experience less negative impact from physical illnesses and disabilities than older women or ethnic-minority men. And yet, in studies with European or mostly European American samples, physical illness, impairment, and pain appear to be more important suicide risk factors for older men than for older women (Fässberg et al. 2015). For example, high overall physical-illness burden was associated with suicide for men, but not for women, in Sweden (Waern et al. 2002). With regard to pain, in a Canadian study, the association of severe pain and suicide was stronger in men than in women (Juurlink et al. 2004). Similarly, a US study found that, among older adults receiving home-care services, the presence of severe pain elevated the risk of self-injury ideation in men but not in women (Li and Conwell 2010). The fact that physical illness, impairment, and pain are more important suicide risk factors for older men than for older women, though older women experience more illness, disability, and pain than older men, suggests that older men may be less psychologically equipped than older women to cope with illnesses, disability, and pain.

Are Suicide Rates Highest among Older Men of European Descent because They Experience More Social Adversities than Older Women or Ethnic-minority Older Men?

Older adult suicide has been linked to the social adversities of aging. Death of a spouse and living alone are among the late-life situations theorized to contribute to older adults' high suicide rates (Chiu and Tsoh 2013; Conwell 2001).

Could older men be more likely to take their lives than older women because they are more likely to experience widowhood and to live alone? In the United States, the opposite is actually true. Men are nearly three times less likely than older women to be widowed, mostly because they tend to marry younger women, and because they have a shorter life expectancy. Men are also more likely than women to remarry after widowhood (and after divorce). Seventy-two percent of men aged sixty-five and older were married in 2012, compared to 45 percent of their female age peers. As a result, older men are less likely to live alone than older women (Torres 2014).

In conclusion, older men are less likely than older women to be exposed to the social adversities of aging, widowhood, and living alone, most commonly associated with suicide. At the same time, in European and European-descent populations, widowhood appears to be more of a suicide risk factor for men than for women (Ajdacic-Gross et al. 2008; Erlangsen et al. 2004; Li 1995; Yip 1998; however, see Turvey et al. 2002, for an exception). For example, a Swiss study found that suicide risk was elevated in the first week after bereavement for both older women and older men, but thereafter it remained elevated only in older men (Ajdacic-Gross et al. 2008). The evidence on living alone and suicide is difficult to interpret, and for many reasons, including the fact that living alone is a weak proxy of feeling lonely—the factor that may be truly suicidogenic (Holwerda et al. 2012). In any case, living alone is not consistently associated with a higher probability of suicidality among older adults (Conwell 2001; Fässberg et al. 2012). Inconsistent is also the evidence on the association of frequency of social contact and suicidality (Fässberg et al. 2012). The fact that widowhood appears to be a more important suicide risk factor for older men than for older women, though older women are more likely to experience the loss of a spouse, suggests that older men may be less psychologically equipped than older women to cope with widowhood, and with being on their own.

Are Suicide Rates Highest among Older Men of European Descent because They Experience More Work or Financial Adversities than Older Women or Ethnic-minority Older Men?

Retirement and financial difficulties are late-life experiences believed to contribute to older adults' high suicide rates (Chiu and Tsoh 2013; De Leo and Diekstra 1990). Are older men of European descent more likely to kill themselves than older women or ethnic-minority men because of their greater exposure to the stress of retirement and/or the economic challenges of aging?

Questions of gender and retirement require consideration of the different work histories and experience of women and men (Calasanti 1993; Moen 1996). First, men as a group experience more favorable (e.g., higher pay, higher status, and greater continuity) employment conditions throughout their work history than women or ethnic-minority men. Second, men's employment is less likely than women's to have been interrupted by caregiving responsibilities (Torres 2014). Third, formal and full

occupational retirement has been and still is more normative for men than for women. Women in the workforce carry the vast majority of house and caregiving responsibilities, prior to and post retirement (Meyer and Parker 2011). This means that, relative to men, women have a greater work burden, prior to retirement from paid labor, but also that they experience a less dramatic change in work pace and type, after retirement. Hence, men's and women's retirement experiences are different—in ways that advantage men in some ways, and women in other ways. Retirement often involves greater identity and social losses for men than for women because for men, employment is a primary site of social engagements, due to men's low involvement in kin- and friend keeping and caregiving (Granville and Evandrou 2010; Lyons 1984; Lumsdaine and Vermeer 2015). At the same time, retirement does not bring as serious economic challenges for men as it does for women (Gregoire, Kilty, and Richardson 2002). In any case, retirement from paid labor is not per se a negative experience. Studies find that many retirees look forward to and are satisfied with retirement (Calasanti 1996; Kim and Moen 2001). In addition, retirement can be especially difficult for women because it often comes after too few years of uninterrupted paid work, before they have had the time to attain their occupational goals and/or to accumulate postretirement income, and/or involuntarily, in response to the care needs of their spouses or grandchildren (Hatch 1992; Price and Balaswamy 2009). For all these reasons, it is not evident that retirement would be so much more stressful for European-descent older men that it would account for their high suicide rates, relative to older women or ethnic-minority men.

With regard to financial resources, older men of European descent are advantaged, relative to older women or ethnic-minority men. European American older men are less likely to be poor than older women, especially relative to ethnic-minority older women with low rates of suicide. In 2011, the poverty rate for US men over sixty-five was 6.2 percent, as compared to 10.7 percent for US women (Torres 2014).

In conclusion, European-descent older men are not more exposed than older women or ethnic-minority men to two late-life occupational and economic situations, retirement and financial difficulties, commonly associated with suicide risk. In any case, evidence on the role of retirement and financial problems in older persons' suicide is weak. A psychological autopsy, case-control study of suicide in mostly (73 percent) male, nearly all (98 percent) European-descent individuals aged fifty and older found that changes in employment (which included but was not restricted to retirement) distinguished the suicides from the controls. However, the suicides were not more likely than the controls to have retired the year prior the suicide (Duberstein et al. 2004). In a Swedish psychological autopsy study, financial problems distinguished older adult suicides (56 percent male) from case controls but not after controlling for mental disorders (Rubenowitz et al. 2001). In Duberstein and colleagues' 2004 US study, lower annual income differentiated suicide decedents from controls, but this finding did not hold in the multivariate analyses.

Why Are Suicide Rates Highest among Older Men of European Descent? Do Individual Factors Explain Their Vulnerability?

The second set of issues to evaluate in order to make sense of European-descent older men's high suicide rates is individual factors. The individual factors most often mentioned in the literature are mental disorders, personality, and coping style.

Are Suicide Rates Highest among Older Men of European Descent because They Suffer from More, or More Serious Mental Disorders, Relative to Older Women or Ethnic-minority Older Men?

In the United States, mental disorders are viewed as a major factor in older adult suicide. A dominant perspective is that the evidence linking "psychiatric illnesses" and suicide is unequivocal: "major affective illness is the factor associated with the highest population-attributable risk for suicide in later life," wrote Conwell (2014, S245). The evidence on the role of mental disorders in general, and major depression specifically, in older adult suicide is however difficult to evaluate. One reason is that information on the mental-disorder status of suicide decedents often comes from psychological autopsy studies, where diagnoses are assigned retrospectively, on the basis of interviews with the bereaved by suicide.

Could a higher burden of mental disorders be an explanation for European-descent older men's suicide rates, relative to older women or ethnic-minority older men? Are European-descent older men uniquely affected by affective disorders? To start, it is important to note that older adults report more emotional well-being and stability than young adults (Carstensen et al. 2011). Also, major depression is less prevalent among older adults than among younger adults (Fiske, Wetherell, and Gatz 2009), especially in "developed" countries, with the association between depression and physical illness decreasing with age (Kessler et al. 2010).

In any case, studies do not find that older men have higher rates of depression than older women. In fact, the opposite seems true. According to a review of studies of European American and European older adults, depressive disorders and depressive symptoms were more, or similarly common in women, relative to men (Djernes 2006). Very little is known about older adults' mental disorders by sex and ethnicity. The available evidence suggests few differences in depressive symptoms between African American and European American older adults (US Department of Health and Human Services 2001).

Taken together, these findings suggest that, by conventional measures, older men have lower rates of mental disorders, including depression, than older women (or, at most, rates of mental disorders that are similar to those of older women). In addition, European American older adults do not appear to be more affected by depression than ethnic-minority older adults with low rates of older adult suicide, such as

African Americans. Based on the available evidence, therefore, it does not appear that mental disorders in general, and depression specifically, account for the high suicide rates of older men of European descent. It may be that suicide in older men of European descent is not connected with depression. Or it may be that depression in older men of European descent is under-recognized and underdiagnosed. A factor contributing to older men's discordant rates of depression and suicide may also be these men's reluctance to acknowledge being depressed and to seek help for their depression (Addis 2008). In any case, the psychological autopsy evidence on the mental health status of (mostly male) suicide decedents is that most of these decedents were diagnosable as depressed. As noted above, this evidence is however problematic because it is often based on retrospective, post-suicide diagnosing.

Are Suicide Rates Highest among Older Men of European Descent because of Their Dysfunctional Coping or Personality?

Coping style and personality have been theorized as playing a role in suicide proneness in general, and in older men's suicide vulnerability, specifically. A version of this theory is that older men are more likely to kill themselves because they do not acquiesce to the losses of aging, as women presumably do. Older women's resilience to suicide comes from their "passivity, suggestibility, and malleability," argued Breed and Huffine (1979, 301). According to Breed and Huffine, older men's difficulties in accommodating to age-related changes results from their lack of practice with changes: a man "is not likely to experience major qualitative change after the first few years of adulthood and marriage. In his developmental process ... the demands and expectations on him are consistent throughout—he is expected to be assertive, to seek mastery over his environment, and to strive for achievement" (p. 302). By contrast, according to them, women have practice with losses, their roles and status likely having shifted through adulthood: for example, "during ... mothering, the woman may well be in and out of the labor market," they say (p. 302). Another version of this theory is that older men are more likely to take their own lives because they are less flexible in their coping with the normal changes of aging than older women (Canetto 1992, 1995a). An important feature of the latter version of the coping theory is that accepting and adapting to aging changes are positively framed, as resilience and grit, not as passivity and weakness.

Could inflexibility in coping be a factor in European-descent older men's high suicide rates? Research points to rigid coping and being low in openness to experience as common in older adult who died of suicide. Specifically, US psychological autopsy studies found that the (mostly European-descent male) older adult decedents were often remembered as having been rigid, conscientious, disciplined, conservative, habit driven, emotionally unaware and emotionally constricted (Duberstein, Conwell, and Caine 1994; Clark 1993; Horton-Deutsch, Clark, and Farran 1992; Useda et al. 2007). For example, in Horton and colleagues' study, the suicide decedents (93 percent European-descent males) were described as having had a narrow

sense of self and chronic difficulties adapting to ordinary life events. Also, according to Clark, these suicide decedents had not faced particularly severe social or health adversities in their last year of life. In the other psychological autopsy study (Duberstein, Conwell, and Caine 1994), the older adult suicide decedents (88 percent male) were found to have been low in openness to experience, relative to matched controls. Specifically, they had a constricted range of interests, shunned challenges, and were closed to feelings.

In conclusions, there are suggestions in the literature that rigidity in sense of self and coping may be individual dispositions contributing to the suicide proneness of older persons in general, and possibly, older men specifically (Canetto 1992, 1995a, 1997; Duberstein 1995, 2001; Schmutte et al. 2009). Some dimensions of this inflexibility construct map onto aspects of hegemonic-masculinity scripts—for example, the strong-and-silent masculinity script and the independent masculinity script (Mahalik, Good, and Englar-Carlson 2003). It may be that tenacious commitment to dominant masculinity scripts, particularly scripts of autonomy and control, threatens not only men's well-being (Mahalik, Good, and Englar-Carlson 2003; Mahalik, Burns, and Syzdek 2007; Perrig-Chiello and Hutchison 2010) but their survival as well, especially late in life (Canetto 1992, 1997; Möller-Leimkühler 2003; Schmutte et al. 2009). For European-descent men, rigidity in coping and sense of self may be reinforced by gender and ethnic privilege—European-descent men's lives prior to late adulthood having been relatively protected from challenges to status, autonomy, and control (Canetto 1992, 1997).

Why Are Suicide Rates Highest among Older Men of European Descent? Do Cultural Factors Explain These Older Men's Suicide Propensity?

The last set of issues considered relevant to the high suicide rates of older European-descent men are cultural factors. Aspects of cultural scripts of gender and suicide, including suicide beliefs and attitudes as well as suicide method choice, are the most discussed and researched of these cultural factors.

Are Suicide Rates Highest among Older Men of European Descent because in Their Culture Suicide Is Viewed as a Masculine Response to the Status and Power Losses ("the Indignities") of Aging?

It has long been observed that suicide rates vary, often stably, across social, cultural, and national groups (Canetto 1997; Canetto and Lester 1998; Cutright and Fernquist 2000; Nock et al. 2008). This stability suggests cultural influences on suicide. An increasingly well-documented theory is that variations in suicide rates reflect variations in suicide scripts, including differences in suicide acceptability. Studies show that suicidal planning and behavior are most likely among individuals (Joe, Romer,

and Jamieson 2007; Kleiman 2015) for whom, and in communities (Cutright and Fernquist 2004) where suicide is most acceptable.

In different cultures, there are unique conditions when suicide is relatively permissible, and even considered good (e.g., rational, moral, and powerful; Andriolo 1998; Canetto 1997; Canetto and Lester 1998). These conditions represent an aspect of the suicide script of that culture. A suicide script also includes the person expected to engage in suicidal behavior, the suicide method, the emotions and motives expressed by or attributed to the suicidal person and to other individuals associated with the suicidal act, the outcome of the suicidal act (i.e., nonfatal vs. fatal), and the social interpretation and consequences of the suicidal behavior. Suicide scripts, like scripts of any other behavior, are both descriptive and prescriptive. They are implicitly influential rather than consciously adopted (Canetto 1997; Canetto and Lester 1998; Canetto and Sakinofsky 1998).

Studies show that European Americans think that suicide is more acceptable when it involves older adults (Deluty 1988–1989b). In addition, suicide in response to a physical illness is considered most understandable even when the person is not an older adult (Deluty 1988–1989a; Droogas, Siiter, and O'Connell 1982–1983; Hammond and Deluty 1992; Ingram and Ellis 1995; LoPresto, Sherman, and DiCarlo 1994–1995; McAndrew and Garrison 2007; Range and Martin 1990). Furthermore, European Americans have been found to endorse the belief that older adult suicide is a relatively rational response to physical illness (Stice and Canetto 2008; Winterrowd, Canetto, and Benoit 2015). Finally, among mostly European American respondents, men view older adult suicide as more admissible than women do (Winterrowd, Canetto, and Benoit 2015).

There is also evidence of a belief, in European and European-descent communities, that suicide is a masculine act (Canetto 1997; Kushner 1993). An early version of this belief is found in the writings of Durkheim (1951) who argued that killing oneself requires the intelligence and courage only "white" men possess. US empirical studies have confirmed the perception, among predominantly European-descent respondents, of the masculinity of suicide. For example, in one study, male suicide was viewed as less foolish, less wrong, more powerful, and more permissible than female suicide (Deluty 1988–1989b). In another study, suicide was judged more masculine than "attempted" suicide (Linehan 1973). In yet another study, males were more concerned than females about social disapproval of their suicidal ideation (Rich et al. 1992), and with good reason, given that males have been found to be particularly critical of other males who "attempt" and "fail" to take their lives (White and Stillion 1988). Finally, there is evidence that suicide by European-descent, ill older men is interpreted as a reasoned choice exemplifying masculine control, power, and determination (Canetto 1995b, 1997; Canetto and Lester 1998). Consistent with this evidence, a Canadian interview study of mostly European-descent older adults with chronic health problems found that older men described their illnesses as a threat to their identity as autonomous and powerful, and viewed suicide as a masculine way to regain control and dignity. "The hell with it!

Go home and get the gun out and blow your brains out," said seventy-nine years old man in response to the question of how he might handle further declines in his health (Clarke, Korotchenko, and Bundon 2012, 11).

In conclusion, there are suggestions, in the empirical literature, that in European-descent communities, suicide is considered a permissible, if not rational response to physical illness. Older adults with health problems may see themselves, or may be seen by others, as experiencing a situation for which suicide is a reasonable, or even a moral choice. Since in European-descent communities, suicide is also considered a masculine act, and masculinity is associated with physical vigor, it is not surprising that European-descent older men are more likely than European-descent older women to act on this illness and indignities-of-aging suicide script.

Are Suicide Rates Highest among Older Men of European Descent Because They Use More Immediately Lethal Suicide Methods than Older Women or Ethnic-minority Older Men?

It has been argued that men's high suicide mortality, including in late life, is primarily a function of men using more immediately lethal suicide methods (e.g., firearms) than women. Men's use of firearms in suicide is also often taken as an indication of men's higher suicidal intent than women's. Studies show that, in the United States, men are indeed more likely than women to use firearms in suicide, and also that firearms use is major factor in the lethality of suicidal behavior (Spicer and Miller 2000). However, men's suicide mortality is higher than women's, independent of method (in the United States, see Spicer and Miller 2000; in Germany, see Cibis et al. 2012)—which suggests other influences on men's higher mortality across suicide methods. Ultimately, it is important to note that US males' preference for firearms in suicide takes place in a culture that considers guns a masculine method (McAndrew and Garrison 2007). Men's higher suicide mortality from all methods also makes sense in light of the perceived femininity of "attempted suicide" in European-heritage cultures. Once they engage in a suicidal act, European-descent men might not be willing to allow themselves to survive it because of the dominant stigma against men who do not "complete" a suicide (Canetto 1995b, 1997).

Two Case Studies

As an illustration of the ideas presented so far, and to clarify what is meant by masculinity and suicide scripts, the narratives of the suicide of two European-descent older men are presented and analyzed below.

"My Work Is Done: Why Wait?"

These words were in the suicide note penned by George Eastman (1854–1932), the founder of Eastman Kodak. Eastman ended his life, at age seventy-seven, in his bed,

with a gunshot to his heart. His death was declared a suicide "while temporarily deranged" (*Democrat Chronicle* 1932). According to a biographer (Brayer 1996), Eastman was an ever-single man who never had close intimate relationships. His social and affective ties were to his mother and his friends. At the time of his death, Eastman was likely in mourning, having lost, a few weeks earlier, his lifelong friend and business associate, Walter Hubbell. In typical male-suicide narrative mode, however, his suicide was explained as the unemotional act of an older, ill man who did not wish to suffer the indignities of aging and was determined to be in charge of his death, as he had been in charge of his life. In an article published soon after his suicide in the *Democrat Chronicle* (1932), his physician was cited as declaring that "ill health … undoubtedly inspired the act." In the same article, a business associate was quoted as stating: "By his own hand he lived his life; and by his own hand he ended it." While there is mention, in the article, that Eastman's lifelong friend had just died, the potential emotional impact of the friend's death on Eastman's decision to suicide is not considered. Rather, attention is drawn to the fact that, prior to his death, the friend had been confined to bed. It is speculated that Eastman wanted to avoid becoming dependent as his friend had: "he planned carefully to end his orderly life in an orderly way" (*Democrat Chronicle* 1932). In a 1963 analysis of Eastman's suicide, Dublin argued that Eastman's suicide was a rational act triggered by the "serious and painful sickness" he had been suffering. "Rather than become a burden to himself or his friends, he shot himself. … His intimates were confident that at the time of this demise, Eastman … was as rational as ever," wrote Dublin (p. 5). The common theme in Eastman's suicide narratives, across commentators, is exemplified in his biographer's statement that Eastman was unprepared and unwilling "to face the indignities of old age" (Brayer 1996, 516).

"Sixty-seven. You Are Getting Greedy. Act Your Old Age. Relax. This Won't Hurt"

These were the final words of the suicide note left by journalist and author Hunter Thompson (1937–2005). Thompson ended his life in his house, with a gunshot into his mouth, at the age of sixty-seven (Brinkley 2005). Thompson was famous for his Gonzo, personally involved style of reporting and his contempt for authority. Close family and friends interviewed soon after his death insisted that his suicide was the planned, rational choice of an irrepressibly transgressive man. "He died … as he planned … with a single, courageous … gunshot," "with a bang," "on his own terms on his own time," they said. "This [suicide] is a triumph of his, not a desperate, tragic failure," and "He was not going to suffer the indignities of old age," they affirmed (Jacoby 2005; Nanji 2005). This rebel suicide narrative, however, crumbled when his suicide note was published in *Rolling Stone* September 8, 2015 (Brinkley, 2005), several months after his death. "They found Hunter S. Thompson's suicide note, and it twists our moral telescope back into the focus we had when we first heard that he'd shot himself in the head," wrote Allen in a

September 9, 2005 *Washington Post* article. "When he took himself out, we wanted to think that it was a .45 caliber hara-kiri, an act of honor by a 67-year old cultural hero who … faced old age …. But no, we quickly learned that it wasn't that pretty" continued Allen. "He killed himself while talking on the phone with his wife, Anita. In the house with him were his son Juan, and his grandson. Not so honorable. You are supposed to go out behind the woodshed, face the existential solitude and let your survivors find you later."

Thompson's suicide note (No More Walking. No More Fun … 67. That is 17 years past 50. 17 more than I needed or wanted. Boring … 67. You are getting greedy. Act your old age. Relax. This won't hurt) and the way Thompson went about killing himself (at home, and while on the phone with his wife) give hints of an emotionally troubled man who was ambivalent about taking his life. A man who perhaps wished to live and to be invited to live, and be loved, as he was, with his infirmities, but who was perhaps afraid to accept himself, and to ask to be accepted as vulnerable and unexciting. His long-divorced first wife, Sondi Wright, was the only person in his entourage to suggest that Thompson killed himself a lonely and desperate man (Stephenson 2012)—a man perhaps tired of the macho persona. By contrast, his closer kin and friends insisted his suicide was a Gonzo triumph over the indignities of aging, and blasted his ashes through a cannon, in celebration.

Analysis

Eastman's and Thompson's suicides were narrated through the codes of European American conventional masculinity. The dominant story is that their suicide was a rational, courageous, decisive choice. They were men who were not going to put up with the indignities of aging, we are told. In both stories, information about feelings, personal shortcomings, and relationship needs was missing. While both suicides were constructed as a form of masculine mastery, in Eastman's case, stoic mastery is the main script, while Thompson's is an example of an exhibitionist macho script. Both men were assumed to have been firm about their suicide. Their suicide notes (by omission, consistent with the stoic script, in the case of Eastman, and loudly, by his own words of fear and ambivalence, in the case of Thompson), however, raise questions about the interpretation of their suicide as an unemotional, unambivalent act.

Discussion and Conclusions

This article started with the observations that older men are more likely to die by suicide than older women and that, in the United States, European-descent older men have the highest suicide rates. This article's main questions questions were: Are older European-descent men more prone to suicide because they are uniquely exposed to presumably suicidogenic aging adversities? What may be the individual

factors associated with their suicide vulnerability? And, what cultural factors may be at play?

This analysis challenged widespread suicide myths in the professional and popular literature, including the idea that interpersonal losses (e.g., widowhood) are relatively unimportant in older male suicide. It also highlighted often overlooked facts in European-descent older men's suicide proneness, including the fact that European-descent older men have *less* exposure than older women to many of the conditions (e.g., depression, chronic illnesses and functional disabilities, financial difficulties, widowhood, and living alone) assumed to increase suicide risk in older adults. Therefore, aging adversities burden per se does not explain the extraordinary suicide proneness of European-descent older men, relative to older women or ethnic-minority older men. Suicide for many European-descent older men seems to be a response to the ordinary challenges and losses of aging.

Cues to European-descent older men's suicide propensity, despite and perhaps because of their relatively privileged status among older adults, and often in the absence of extraordinary age-related adversities, came from studies of the personality of suicide decedents. In these studies, the (mostly) European-descent older adult (mostly) male decedents were described as having displayed traits (e.g., closeness to new experiences) and ways of coping (e.g., inflexible) consistent with dimensions of dominant scripts of masculinity. More cues to European-descent older men's suicide vulnerability came from the cultural-scripts-of-suicide literature, via the evidence on beliefs, in predominantly European-descent communities, about the masculinity of suicide as well as the evidence on the acceptability of suicide under conditions of ill-health and when the person is older adult. Taken together, this individual and cultural evidence suggests that older male suicide may be enabled by its cultural acceptability, and also by its masculine connotation. European American men who rigidly and tenaciously abide to hegemonic-masculinity scripts, particularly the independent (as in the case of Eastman) or the macho (as in the case of Thompson) scripts, may be both least equipped for the challenges of aging, and most vulnerable to the indignities of aging suicide script. European American men may be particularly likely to act on the indignities-of-aging suicide script due to the connection, in European American culture, between masculinity and physical vigor, control, and autonomy.

Among the implications, for suicide prevention, of the findings of this analysis is the importance to examine and address the dominant and idiosyncratic, community and individual suicide scripts. With regard to the prevention of suicide among European-descent older men, the findings of this analysis point to the value of challenging the indignities-of-aging suicide script as well as the belief that suicide is a masculine response to aging. Education about the costs and dangers, with regard to suicide, of certain aspects (e.g., the being-in-control dimension) of dominant ideologies of masculinity would also likely be useful in initiatives aimed at reducing European-descent older male suicidality (Canetto 1997; Canetto and Cleary 2012; Canetto and Lester 1998; Canetto and Sakinofsky 1998; Möller-Leimkühler 2003;

Oliffe et al. 2011; Springer and Mouzon 2011; Stanistreet, Bambra, and Scott-Samuel 2005).

There are limitations to this analysis. A chief limitation is that few older adult suicide studies included sex-specific information, and even fewer had sex-by-ethnicity data. Another limitation is that it focused on the United States, a country that is overrepresented in the suicide literature. As noted in the introduction, patterns of older adult suicide in the United States specifically, and in high-income countries generally, are at variance with patterns of older adult suicide in low- and middle-income countries. Considering that 75 percent of global suicides occur in low- and middle-income countries (World Health Organization 2014), it is important to examine the gender and cultural scripts of older adult suicide in those countries, and see the lessons they teach us about suicide risk and protection there, and elsewhere.

A contribution of this analysis is that it makes visible gender and cultural patterns and paradoxes of older adult suicide in the United States, the chief paradox being that the most privileged of older adults, men of European descent, are the most suicide prone. This analysis points to the importance of attending to meanings and practices of masculinity in relation to meanings of aging and meanings of suicide, to make sense of the suicidality of European-descent older men. Finally, this analysis shows how gender and culture lenses generally expand our understanding of older men's suicide proneness as well as, likely, our tools for its prevention.

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References

Addis, M. E. 2008. "Gender and Depression in Men." *Clinical Psychology: Science and Practice* 15:153–68.

Ajdacic-Gross, V., M. Ring, E. Gadola, C. Lauber, M. Bop, F. Gutzwiller, and W. Rössler. 2008. "Suicide After Bereavement: An Overlooked Problem." *Psychological Medicine* 38:673–76.

Allen, H.2005. "Last Words: A Testament to Hunter Thompson." *The Washington Post*. Accessed May 1, 2015. http://www.washingtonpost.com/wp-dyn/content/article/2005/09/08/AR2005090801993.html.

Andriolo, K. R. 1998. "Gender and the Cultural Construction of Good and Bad Suicides." *Suicide and Life-Threatening Behavior* 28:37–49.

Bird, C. E., and P. P. Rieker. 2008. *Gender and Health: The Effect of Constrained Choices and Social Policies*. New York: Cambridge Press.

Brayer, E. 1996. *George Eastman: A Biography*. Baltimore, MD: The John Hopkins Press.

Breed, W., and C. L. Huffine. 1979. "Sex Differences in Suicide among Older White Americans: A Role and Developmental Approach." In *Psychopathology of Aging*, edited by C. J. Kaplan, 280–309. New York: Academic Press.

Brinkley, D. 2005. "Football Season Is over Dr. Hunter S. Thompson's Final Note . . . Entering the No More Fun Zone." *Rolling Stone*. Accessed May 1, 2015. http://web.archive.org/web/20080619074031/http://www.rollingstone.com/news/story/7605448/football_season_is_over.

Calasanti, T. M. 1993. "Bringing in Diversity: Toward an Inclusive Theory of Retirement." *Journal of Aging Studies* 7:133–50.

Calasanti, T. M. 1996. "Gender and Life Satisfaction in Retirement: An Assessment of the Male Model." *Journal of Gerontology Series B-Psychological Sciences and Social Sciences* 51:S18–29.

Cameron, K. A., J. Song, L. M. Manheim, and D. D. Dunlop. 2010. "Gender Disparities in Health and Healthcare Use among Older Adults." *Journal of Women's Health* 19: 1643–50.

Canetto, S. S. 1992. "Gender and Suicide in the Elderly." *Suicide and Life-Threatening Behavior* 22:80–97.

Canetto, S. S. 1995a. "Elderly Women and Suicidal Behavior." In *Women and Suicidal Behavior*, edited by S. S. Canetto and D. Lester, 215–33. New York: Springer.

Canetto, S. S. 1995b. "Men Who Survive a Suicidal Act: Successful Coping or Failed Masculinity?" In *Men's Health and Illness: Gender, Power, and the Body*, edited by D. Sabo and D. Gordon, 292–304. Newbury Park, CA: Sage.

Canetto, S. S. 1997. "Gender and Suicidal Behavior: Theories and Evidence." In *Review of Suicidology*, edited by R. W. Maris, M. M. Silverman, and S. S. Canetto, 138–67. New York: Guilford.

Canetto, S. S., and A. Cleary. 2012. "Men, Masculinities and Suicidal Behavior." *Social Science & Medicine* 74:461–65.

Canetto, S. S., and D. Lester. 1998. "Gender, Culture and Suicidal Behavior." *Transcultural Psychiatry* 35:163–91.

Canetto, S. S., and I. Sakinofsky. 1998. "The Gender Paradox in Suicide." *Suicide and Life-Threatening Behavior* 28:1–23.

Carstensen, L. L., B. Turan, S. Scheibe, N. Ram, H. Ersner-Hershfield, G. R. Samanez-Larkin, K. P. Brooks, and J. R. Nesslroade. 2011. "Emotional Experience Improves with Age: Evidence Based on over 10 Years of Experience Sampling." *Psychology and Aging* 26:21–33.

Centers for Disease Control and Prevention. n.d. "National Suicide Statistics at a Glance." Accessed June 8, 2015. http://www.cdc.gov/violenceprevention/suicide/statistics/rates05.html.

Chiu, H., and J. Tsoh. 2013. "Suicide and Attempted Suicide in Older People." In *Oxford Textbook of Old Age Psychiatry*, edited by T. Dening and A. Thomas, 571–79. New York: Oxford University Press.

Cibis, A., R. Mergl, A. Bramesfeld, D. Althaus, G. Niklewski, A. Schmidtke, and U. Hegerl. 2012. "Preference for Lethal Methods Is Not the Only Cause for Higher Suicide Rates in Males." *Journal of Affective Disorders* 136:9–16.

Clark, D. C. 1993. "Narcissistic Crises of Aging and Suicidal Despair." *Suicide and Life-Threatening Behavior* 23:21–26.

Clarke, L. H., A. Korotchenko, and A. Bundon. 2012. "'The Calendar Is Just About Up': Older Adults with Multiple Chronic Conditions Reflect on Death and Dying." *Ageing and Society* 32:399–417.

Conwell, Y. 2001. "Suicide in Later Life: A Review and Recommendations for Prevention." *Suicide and Life-Threatening Behavior* 31:32–47.

Conwell, Y. 2014. "Suicide in Later Life: Challenges and Priorities for Prevention." *American Journal of Preventive Medicine* 47:S244–50.

Conwell, Y., and A. O'Riley. 2013 "The Challenge of Suicide Prevention in Later Life." In *Late-life Mood Disorders*, edited by H. Lavretsky, M. Sajatovic, and C. F. Reynolds III, 206–19. New York: Oxford University Press.

Cutright, P., and R. M. Fernquist. 2000. "Effects of Societal Integration, Period, Region, and Culture of Suicide on Male Age-specific Suicide Rates: 20 Developed Countries, 1955–1989." *Social Science Research* 29:148–72.

Cutright, P., and R. M. Fernquist. 2004. "The Culture of Suicide through Social Integration and Regulation: 1996–1998: Gender-specific Suicide Rates in 50 American States." *Archives of Suicide Research* 8:271–85.

De Leo, D., and R. F. W. Diekstra. 1990. *Depression and Suicide in Late Life*. Toronto, Canada: Hogrefe & Huber.

Deluty, R. H. 1988–1989a. "Physical Illness, Psychiatric Illness, and the Acceptability of Suicide." *Omega: The Journal of Death and Dying* 19:79–91.

Deluty, R. H. 1988–1989b. "Factors Affecting the Acceptability of Suicide." *Omega: The Journal of Death and Dying* 19:315–26.

Democrat Chronicle. 1932. "George Eastman Is Mourned: Takes Own Life; 'Work Done, Why Wait?' He Writes." March 13, Section I, p. 1.

Djernes, J. K. 2006. "Prevalence and Predictors of Depression in Populations of Elderly: A Review." *Acta Psychiatrica Scandinavica* 113:372–87.

Droogas, A., R. Siiter, and A. N. O'Connell. 1982-1983. "Effects of Personal and Situational Factors on Attitudes toward Suicide." *Omega: The Journal of Death and Dying* 13:127–44.

Duberstein, P. R. 1995. "Openness to Experience and Completed Suicide across the Second Half of Life." *International Psychogeriatrics* 7:183–98.

Duberstein, P. R. 2001. "Are Close-minded People More Open to the Idea of Killing Themselves?" *Suicide and Life-Threatening Behavior* 31:9–14.

Duberstein, P. R., Y. Conwell, and E. D. Caine. 1994. "Age Differences in the Personality Characteristics of Suicide Completers: Preliminary Findings from a Psychological Autopsy Study." *Psychiatry* 57:213–24.

Duberstein, P. R., Y. Conwell, K. R. Conner, E. Eberly, and E. D. Caine. 2004. "Suicide at 50 Years of Age and Older: Perceived Physical Illness, Family Discord and Financial Strain." *Psychological Medicine* 34:137–46.

Dublin, L. I. 1963. *Suicide: A Sociological and Statistical Study*. New York: Ronald.

Durkheim, E. 1951. *Suicide: A Study in Sociology*. New York: Free Press.

Erlangsen, A., B. Jeune, U. Bille-Brahe, and J. W. Vaupel. 2004. "Loss of Partner and Suicide Risks among Oldest Old: A Population-based Register Study." *Age Ageing* 33:378–83.

Fässberg, M. M., G. Cheung, S. S. Canetto, A. Erlangsen, S. Lapierre, L. Reinhart, B. Draper, J. J. Gallo, C. Wong, J. Wu, P. Duberstein, and M. Waern. 2015. "A Systematic Review of Physical Illness, Functional Disability and Suicidal Behavior in Later Life." *Aging & Mental Health*. doi:10.1080/13607863.2015.1083945.

Fässberg, M. M., K. Van Orden, P. Duberstein, A. Erlangsen, S. Lapierre, E. Bodner, S. S. Canetto, D. De Leo, K. Szanto, and M. Waern. 2012. "A Systematic Review of Social Factors and Suicidal Behavior in Older Adulthood." *International Journal of Environmental Research and Public Health* 9:722–45.

Fiske, A., J. L. Wetherell, and M. Gatz. 2009. "Depression in Older Adults." *Annual Review of Clinical Psychology* 5:363–89.

Fung, Y. L., and Z. C. Y. Chan. 2011. "A Systematic Review of Suicidal Behavior in Old Age: A Gender Perspective." *Journal of Clinical Nursing* 20:2109–24.

Granville, G., and M. Evandrou. 2010. "Older Men, Work and Health." *Occupational Medicine* 60:178–83.

Gregoire, T. K., K. Kilty, and V. Richardson. 2002. "Gender and Racial Inequities in Retirement Resources." *Journal of Women and Aging* 14:25–39.

Hammond, L. K., and R. H. Deluty. 1992. "Attitudes of Clinical Psychologists, Psychiatrists, and Oncologists toward Suicide." *Social Behavior and Personality* 20:289–94.

Hatch, L. R. 1992. "Gender Differences in Orientation toward Retirement from Paid Labor." *Gender and Society* 6:66–85.

Hayutin, A. M., M. Dietz, and L. Mitchell. 2010. *New Realities of an Older America: Challenges, Changes and Questions*. Stanford Center on Longevity. Accessed May 6, 2015. http://longevity3.stanford.edu/wp-content/uploads/2013/01/New-Realities-of-an-Older-America.pdf.

Hess, B. H. 1990. "The Demographic Parameters of Gender and Aging." *Generations* 14:12–16.

Holwerda, T. J., A. T. F. Beekmam, D. J. H. Deeg, M. L. Stek, T. G. van Tilburg, P. J. Visser, B. Schmand, C. Jonker, and R. A. Choevers. 2012. "Increased Risk of Mortality Associated with Social Isolation in Older Men: Only When Feeling Lonely? Results from the Amsterdam Study of the Elderly (AMSTEL)." *Psychological Medicine* 42:843–53.

Horton-Deutsch, S. L., D. C. Clark, and C. J. Farran. 1992. "Chronic Dyspnea and Suicide in Elderly Men." *Hospital and Community Psychiatry* 43:1198–203.

Ingram, E., and J. B. Ellis. 1995. "Situational Analysis of Attitudes toward Suicide Behavior." *Death Studies* 19:269–75.

Jacoby, J. 2005. *No Glory in Suicide*. Accessed May 7, 2015. http://www.boston.com/news/globe/editorial_opinion/oped/articles/2005/03/03/no_glory_in_suicide/.

Joe, S., D. Romer, and P. E. Jamieson. 2007. "Suicide Acceptability is Related to Suicide Planning in U.S. Adolescents and Young Adults." *Suicide and Life-Threatening Behavior* 37:165–78.

Juurlink, D. N., N. N. Herrmann, J. P. Szalai, A. Kopp, and D. Redelmeier. 2004. "Medical Illness and the Risk of Suicide in the Elderly." *Archives of Internal Medicine* 164:1179–84.

Kessler, R. C., H. G. Birnbaum, V. Shahly, E. Bromet, I. Hwang, K. A. McLaughlin, N. Sampson, L. H. Andrade, G. de Girolamo, K. Demyttenaere, J. M. Haro, A. N. Karam, S. Kostyuchenko, V. Kovess, C. Lara, D. Levinson, H. Matschinger, Y. Nakane, M. O. Browne, J. Ormel, J. Posada-Villa, R. Sagar, and D. J. Stein. 2010. "Age Differences in the Prevalence and Co-morbidity of DBM-VI Major Depressive Episodes: Results from the WHO World Mental Health Survey Institute." *Depression and Anxiety* 27:351–64.

Kim, J. E., and P. Moen. 2001. "Is Retirement Good or Bad for Subjective Well-being?" *Current Directions in Psychological Science* 10:83–86.

Kleiman, E. M. 2015. "Suicide Acceptability as a Mechanism of Suicide Clustering in a Nationally Representative Sample of Adolescents." *Comprehensive Psychiatry* 59:17–20.

Kushner, H. I. 1993. "Gender and the Irrelevance of Medical Innovation: The Social Construction of Suicide as a Male Behavior in Nineteenth Century Psychiatry." In *L'Innovation en Medicine: Études Historiques et Sociologiques*, edited by I. Lowy, 421–45. Paris, France: Les Editions INSERM/Libby Eurotext.

Li, G. 1995. "The Interaction Effect of Bereavement and Sex on the Risk of Suicide in the Elderly: An Historical Cohort Study." *Social Science & Medicine* 40:825–28.

Li, G., and Y. Conwell. 2010. "Pain and Self-injury Ideation in Elderly Men and Women Receiving Home Care." *Journal of the American Geriatrics Society* 58:2160–65.

Linehan, M. M. 1973. "Suicide and Attempted Suicide: Study of Perceived Sex Differences." *Perceptual and Motor Skills* 37:31–34.

Link, B., J. C. Phelan, and A. M. Fremont. 2000. "Evaluating the Fundamental Cause Explanation for Social Disparities in Health." In *Handbook of Medical Sociology*, 5th ed., edited by C. E. Bird and P. Conrad, 33–46. Upper Saddle River, NJ: Prentice Hall.

LoPresto, C. T., M. F. Sherman, and M. A. DiCarlo. 1994–1995. "Factors Affecting the Unacceptability of Suicide and the Effects of Evaluator Depression and Religiosity." *Omega: The Journal of Death and Dying* 30:205–21.

Lumsdaine, R. L., and S. G. C. Vermeer. 2015. "Retirement Timing of Women and the Role of Care Responsibilities for Grandchildren." *Demography* 52:433–54.

Lyons, M. J. 1984. "Suicide in Later life: Some Putative Causes with Implications for Prevention." *Journal of Community Psychology* 12:379–88.

Mahalik, J. R., S. M. Burns, and M. Syzdek. 2007. "Masculinity and Perceived Normative Health Behaviors as Predictors of Men's Health Behaviors." *Social Science & Medicine* 64:2201–09.

Mahalik, J. R., G. G. Good, and M. Englar-Carlson. 2003. "Masculinity Scripts, Presenting Concerns, and Help-seeking: Implications for Practice and Training." *Professional Psychology: Research and Practice* 34:123–31.

McAndrew, F. T., and A. J. Garrison. 2007. "Beliefs about Gender Differences in Methods and Causes of Suicide." *Archives of Suicide Research* 11:271–79.

Meyer, M. H., and W. M. Parker. 2011. "Gender, Aging, and Social Policy." In *Handbook of Aging and the Social Science*, 7th ed., edited by R. B. Binstock and L. George, 323–35. Burlington, MA: Elsevier.

Moen, P. 1996. "A Life Course Perspective on Retirement, Gender, and Well-being." *Journal of Occupational Health Psychology* 1:131–44.

Möller-Leimkühler, A. M. 2003. "The Gender Gap in Suicide and Premature Death: Or Why Are Men So Vulnerable?" *European Archives of Psychiatry and Clinical Neuroscience* 253:1–8.

Montgomery, R. J. V., and M. M. Datwyler. 1990. "Women and Men in the Caregiving Role." *Generations* 14:34–8.

Nanji, A. 2005. *Thompson Death Spurs Book Sale*. Accessed June 8, 2015. http://www.cbsnews.com/news/thompson-death-spurs-book-sales/.

National Alliance for Caregiving and American Association of Retired Persons (AARP). 2009. *Caregiving in the U.S., 2009*. Washington, DC: National Alliance for Caregiving and AARP.

Nock, M. K., G. Borges, E. J. Bromet, C. B. Cha, R. C. Kessler, and S. Lee. 2008. "Suicide and Suicidal Behavior." *Epidemiologic Reviews* 30:133–54.

Oliffe, J. L., C. S. E. Han, J. S. Ogrodniczuck, J. G. Phillips, and P. Roy. 2011. "Suicide from the Perspectives of Older Men Who Experience Depression: A Gender Analysis." *American Journal of Men's Health* 5:444–54.

Perrig-Chiello, P., and S. Hutchison. 2010. "Health and Well-being in Old Age: The Pertinence of a Gender Mainstreaming Approach to Research." *Gerontology* 56:208–13.

Price, C. A., and S. Balaswamy. 2009. "Beyond Health and Wealth: Predictors of Women's Retirement Satisfaction." *International Journal of Aging and Human Development* 68:195–214.

Range, L. M., and S. K. Martin. 1990. "How Knowledge of Extenuating Circumstances Influences Community Reactions toward Suicide Victims and their Bereaved Families." *Omega: The Journal of Death and Dying* 21:191–98.

Rich, A. R., J. Kirkpatrick-Smith, R. L. Bonner, and F. Jans. 1992. "Gender Differences in the Psychosocial Correlates of Suicidal Ideation among Adolescents." *Suicide and Life-Threatening Behavior* 22:364–73.

Rubenowitz, E., M. Waern, K. Wilhelson, and P. Allebeck. 2001. "Life Events and Psychosocial Factors in Elderly Suicide—A Case-control Study." *Psychological Medicine* 31:1193–202.

Schmutte, T., M. O'Connell, M. Weiland, S. Lawless, and L. Davidson. 2009. "Stemming the Tide of Suicide in Older White Men: A Call to Action." *American Journal of Men's Health* 3:189–200.

Shah, A., R. Bhat, S. Zarate-Escudero, D. DeLeo, and A. Erlangsen. 2015. "Suicide Rates in Five-year Age-bands After the Age of 60 Years: The International Landscape." *Aging & Mental Health*. doi:10.1080/13607863.2015.1055552.

Spicer, R. S., and T. R. Miller. 2000. "Suicide Acts in 8 States: Incidence and Case Fatality Rates by Demographics and Method." *American Journal of Public Health* 90:1885–91.

Springer, K. W., and D. M. Mouzon. 2011. "'Macho Men' and Preventive Health Care: Implications for Older Men in Different Social Classes." *Journal of Health and Social Behavior* 52:212–27.

Stanistreet, D., C. Bambra, and A. Scott-Samuel. 2005. "Is Patriarchy the Source of Men's Higher Mortality?" *Journal of Epidemiology and Community Health* 59:873–76.

Stephenson, W. 2012. *Gonzo Republic: Hunter S. Thompson's America*. New York: Continuum International.

Stice, B. D., and S. S. Canetto. 2008. "Older Adult Suicide: Perceived Precipitants and Protective Factors." *Clinical Gerontologist: The Journal of Aging and Mental Health* 31:1–25.

Torres, S. 2014. "Aging Women, Living Poorer." *Contexts* 13:72–4. Accessed May 11, 2015. http://contexts.org/articles/aging-women-living-poorer/.

Turvey, C. L., Y. Conwell, M. P. Jones, C. Phillips, E. Simonsick, J. L. Pearson, and R. Wallace. 2002. "Risk Factors for Late-life Suicide: A Prospective, Community-based Study." *American Journal of Geriatric Psychiatry* 10:398–406.

US Department of Health and Human Services. 2001. *Mental Health: Culture, Race and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD. Accessed April 30, 2015. http://www.consumerstar.org/resources/pdf/surgeongeneralsreport2001.pdf.

Useda, J. D., P. R. Duberstein, K. R. Conner, A. Beckman, N. Franus, X. Tu, and Y. Conwell. 2007. "Personality Differences in Attempted Suicide versus Suicide in Adults 50 Years of Age or Older." *Journal of Consulting and Clinical Psychology* 75:126–33.

Värnik, P. 2012. "Suicide in the World." *International Journal of Environmental Research and Public Health* 9:760–71.

Waern, M., E. Rubenowitz, B. Runeson, I. Skoog, K. Wilhelmson, and P. Allebeck. 2002. "Burden of Illness and Suicide in Elderly People: Case-control Study." *British Medical Journal* 324:1355–57.

White, H., and J. M. Stillion. 1988. "Sex Differences in Attitudes toward Suicide: Do Males Stigmatize Males?" *Psychology of Women Quarterly* 12:357–66.

Winterrowd, E., S. S. Canetto, and K. Benoit. 2015. "Permissive Beliefs and Attitudes About Older Adult Suicide: A Suicide Enabling Script?" *Aging & Mental Health*.

World Health Organization. 2014. *Preventing Suicide: A Global Imperative*. Accessed August 10, 2015. http://apps.who.int/iris/bitstream/10665/131056/8/9789241564878_eng.pdf?ua=1&ua=1.

Yip, P. S. 1998. "Age, Sex, Marital Status and Suicide: An Empirical Study of East and West." *Psychological Reports* 82:311–22.

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