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Is Ill-Being Gendered? Suicide, Risk for Suicide, Depression and Alcohol Dependence*

ABSTRACT

Ill-being arises from the multiple interactions involved in a specific tension, that between an individual with social characteristics and the values and norms promoted by the society that individual lives in. The way a person expresses ill-being tends to vary by gender: depression and suicidal behavior are more common among women, whereas suicide and alcohol dependence are more common among men. Focusing on a single way of expressing ill-being could therefore lead to misinterpretation of results. While divergences among ways of expressing ill-being expose the specificities of those ways and their differentiated effects for particular groups, convergences make it possible to arrive at conclusions that can be generalized to all individuals. Gender-specific indicators have been developed on the basis of recent data that capture major changes in the form of the couple and household types. These indicators can be used to examine whether and to what degree women are “protected” against ill-being by having an intimate partner and children. These elements are usually determined on the basis of suicide studies alone.

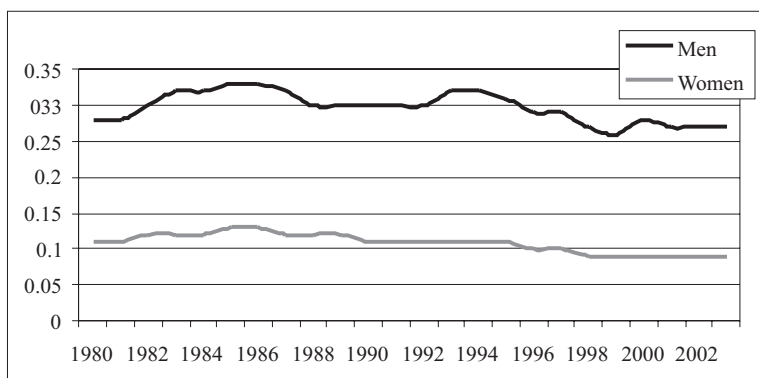
Men are more likely to commit suicide than women –sociology offers few such regular observations. The higher suicide rate for men was first found by nineteenth-century studies; it has been found for nearly all countries except China (Baudelot and Establet, 2006). Analysis of gender differences for suicide, timidly begun by Durkheim, is no longer focused on the problem of explaining this fundamental difference between men and women; sociologists have been more concerned to inquire into the antagonism between what the two sexes stand to gain or lose by marriage. Despite his systematically gender-specific analysis of marital status, Durkheim said little about what

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might explain the gender differential in the “penchant for suicide”, suggesting only that the fact that women did not partake as much in social life might explain their relative “immunity” from suicide. This decidedly unconvincing explanation is already disproved by the fact that the gap between male and female suicide rates has persisted over time despite women’s gradual entry onto the labor market (Figure 1). Durkheim showed that the “marital society” formed by spouses was of greater benefit to men than women. Noting that married women without children were more likely to commit suicide than single women, he concluded that “in itself, conjugal society is harmful to the woman and aggravates her tendency to suicide” (Durkheim [1897] 1997, p. 196, 1951). As he understood it, women’s relative immunity could only be ensured by the presence of children within the household, and therefore by integration into the “domestic society” as a whole, rather than by marriage itself.⁽¹⁾

The antagonism between the interests of the male and female members of a couple came through clearly in the opposite effect produced by divorce. Legalizing divorce reduced the relatively high suicide “preservation” coefficient that married men enjoyed over unmarried men while increasing that coefficient for married women. However, Durkheim failed to explain women’s “excessive” marital regulation with his naturalizing theory of the difference between women’s and men’s sexual desire.⁽²⁾

FIGURE 1. – *Male and female suicide rates in France, 1980-2003*
(per 1,000 persons)



Source: Centre d'Épidémiologie sur les Causes Médicales de Décès (CépiDc, INSERM), deaths 1980-2003.

(1) Durkheim understood the benefits of integration in terms of two complementary poles: family density and collective feelings: “But for a group to be said to have a less common life than another means that it is less powerfully integrated; for the state of integration of a social aggregate can only reflect the intensity of the collective life circulating in it. It is more unified and powerful the more active and constant the

intercourse is among its members. Our previous conclusion may thus be completed to read: just as the family is a powerful safeguard against suicide, so the more strongly it is constituted the greater its protection.” (Durkheim [1897] 1997, p. 214, 1951).

(2) According to Durkheim, marital regulation amounts to moderation of passions (Steiner [1994] 2005, pp. 44-47).

As a close reader of *Suicide*, Philippe Besnard returned to this “unfinished theory”, pointing out married women’s tendency to commit “fatalistic” suicide⁽³⁾ because of the strong social expectations bearing on women’s marriage-related roles: “In reality, it was not only married, childless women (a negligible quantity as far as Durkheim was concerned) but all married women who were subject to the effects of excessive regulation, though the presence of children compensated in part for the harmful effect of marital discipline.” (Besnard, 1973, p. 41). But Besnard did not go any further than Durkheim to explain female “immunity”, acknowledging instead his “inability to imagine a plausible sociological interpretation” (Besnard, 1987a, p. 138). While the antagonism between male and female interests within “conjugal society” is a fundamental question, it is also true that married women’s greater immunity to suicide cannot be explained logically by their disadvantage in the situation of marriage. And marriage itself brings about only relative, limited differences between the two groups. The initial absolute difference is of an entirely different order.

Baudelot and Establet were also addressing the question of women’s immunity to suicide –the primary difference between men and women– when they formulated their hypothesis that women were protected by being more fully integrated into the family: “In France, the woman is statutorily more engaged than the man in family relations. [She is] statutorily more integrated.” (Baudelot and Establet, 1984, p. 101). Contrary to men, women’s integration into the family depends less on the fact of being married; it continues throughout their lives (even when their husbands die); indeed, this may be what explains why they get less protection from marriage itself: “The woman ensures generational continuity: she is never relieved of family obligations. Male autonomy implies a greater risk of solitude.” (*ibid.*, p. 104). This hypothesis is part of a theory of differentiated gender identities based on different male and female roles –son, daughter; husband, wife; father, mother– and socially constructed values (Dubar, 1987). As Besnard points out in his critical exchange with Dubar (Besnard, 1987a, p. 378), it amounts to saying that women actually get a marginal advantage from being dominated, an advantage that gets materialized in their lower suicide rate. This hypothesis, which Besnard rejected, was also put forward by Goldberg (1976): “the idea that males are privileged [...] flies in the face of all the statistics of personal damage: in respect of longevity, proneness to disease, suicide, crime, accidents, alcoholism and drug addiction, women are on average more favoured than men” (quoted in Giddens, 1992, p. 150). According to Goldberg, then, the “hazards of being male” involve heavy costs, including suicide.

(3) Durkheim described fatalistic suicide in a footnote and did not consider it very important because, as he saw it, only married but childless women and “very young husbands” committed that type of suicide. In

his typology, fatalistic suicide and anomic suicide are at opposite poles. Fatalistic suicide results from excessive regulation; it is the suicide of people whose prospects for the future seem irremediably blocked (Besnard, 1987b).

The split between these two positions –Durkheim and Besnard’s on one hand, Baudelot, Establet and Dubar’s on the other– is more readily overcome than may be supposed. In fact, the opposition between them is due to the fact that they are answers to complementary and indeed different questions, one emphasizing the marriage benefit differential, the other women’s relative immunity to suicide. In our analysis we use a gender approach that unifies the problem: both questions have to be handled, but separately. Comparing suicide with other ways of expressing ill-being seems to us a useful, rewarding way of doing this. It requires us to 1) be critical of the notion that women are “overprotected” from suicide and 2) check whether the benefit men get from marriage is confirmed for other ways of expressing ill-being.

Durkheim was trying to found sociology as an autonomous science, so he had to circumscribe his demonstration, examining only the *social* character of what is a profoundly individual act. He could not inquire into personal motives for committing suicide because the diversity of such motives would have complicated the work of identifying social regularities. Concerned above all to invalidate the psychological explanation according to which suicide is an act of the “unique” individual, he refused to acknowledge motives for individual suffering so as to focus more effectively on the social. One of Maurice Halbwachs’ many merits is to have found a way of reconciling the dimension of individual suffering with that of social causes. He was able to do this thanks to Durkheim’s concept of integration. Halbwachs specified that “individual motives for suicide are nonetheless related to general causes and form part of the same system. This may not be perceived if the major currents of collective life are arbitrarily separated from these particular accidents as if there were no connection” (Halbwachs [1930] 2002, p. 383, 1978).

Are the ways of ill-being inscrutable?

In a work published posthumously, Jeremy Bentham explicitly identified suicide as *the* expression of ill-being, defining ill-being as “the balance, if in favour of pain”⁽⁴⁾ (1834, p. 78): “Of well-being, existence is in itself a conclusive proof, for small is the quantity of pain at the expense of which existence may be terminated.” (*ibid.*, p. 79). The connection Bentham makes between ill-being and suicide, though not particularly original, is useful to our purposes here. However, it is difficult to subscribe to his utilitarian conception of suicide as a rational response to ill-being that has become insurmountable. Though an individual may have “good reasons” to end his or her life, is this enough to justify the claim that suicide is a perfectly rational act? Rational choice theory (RCT) posits that individuals are more inclined to kill themselves as the amount of time they have to live diminishes; this is RCT’s answer to the observed increase in suicide with age (Hamermesh and Soss,

(4) Conversely, well-being is “balance in favour of pleasure”.

1974),⁽⁵⁾ and the observation was regularly confirmed until the 1970s. But now suicide rates for young and older men are tending to even out (Chauvel, 1997). Moreover, the explanation seems to apply to men only (Chesnais and Vallin, 1981).⁽⁶⁾ In a brief footnote, Hamermesh and Soss raise the question of why men are more likely than women to commit suicide, claiming that the gender difference is related to demographic suicide factors and therefore can be explained only by sociological theory, not economic theory. As they understand it, this is enough to justify restricting the rest of their analysis to men. But in the conceptual framework of rational choice theory, the hypothesis that women are less likely to commit suicide should be explained by the fact that at older ages they are not as solitary as men, and that young women are less likely to be unemployed. However, women are more likely to be widowed and off the labor market, so these claims run directly counter to the facts. Unless we go back to naturalizing differences between men and women—in this case, adopting the idea that women are less rational or endowed with another kind of rationality—the notion that killing oneself is purely rational fails to explain one of the most striking social regularities of suicide.

Similarly to Bentham, economists have defined well-being first and foremost as a utility function for satisfying the actor's desires and preferences. The economics of well-being (a prolific field), like economics of happiness and hedonist psychology,⁽⁷⁾ has gone beyond this first, oversimplified outline by insisting on the fact of *relative* well-being. Research in this field has shown that levels of declared happiness are the same in all nations, regardless of economic condition. It also reveals higher female satisfaction about own occupational situation than for men working in better conditions; this is explained by the fact that women do not compare their situation to men's but rather to mother's occupation (Clark, 1997; Baudelot, Gollac, Bessières *et al.*, 2003). For our purposes, well-being has to be evaluated relative to a situation that is the implicit norm in a given country; also relative to a reference point that people use. This is so because well-being is a function of actors' relative positions, namely gender, and therefore ultimately of the norms and values they incorporate during their lives.

In the occupational sphere, employees' happiness as regards their work involves two dimensions: to be (or do), and to have (Baudelot, Gollac, Bessières *et al.*, 2003). For some respondents, it means having a family, a

(5) Baudelot and Establet sociologically reformulated this idea using Halbwachs' concept of how an individual's time is structured by social frameworks: "It is highly probable that the quantity of existence [...] is conceived in terms of affective experiences to be lived, children and grandchildren to be born, birthday wishes to be given." Age is understood to intervene as a temporal "what is left to live": "an adolescent [who commits suicide] is not sacrificing the same quantity of existence as a sexagenarian" (1984, pp. 105-106). The authors

did not reiterate this idea in their more recent work, *Suicide: l'envers de notre monde* [*Suicide: The Underside of Our World*] (2006).

(6) And the hypothesis cannot stand up to examination of men's and women's suicide curves. If we take into account the discrepancy due to unequal life expectancies for the two sexes, the curves should be parallel for the same quantity of life being sacrificed. This is not the case (see Figure 2).

(7) For a review of economics-of-well-being literature, see Davoine (2007).

house, a job, money; for others, it amounts to feeling good about oneself, at peace, having good relationships with one's children, husband, significant other, etc. However, this second group notes that in order to *be* or to realize one's potential, one already has to *have*. At the other end of the spectrum are situations where employees are suffering or have withdrawn. This means that "unhappiness" in work is not the exact opposite of happiness. It therefore will not suffice to define ill-being or unhappiness merely as the opposite of the similar terms "well-being" or "happiness". Still, the two notions are obviously related. For Schopenhauer, happiness was to be found not in a perpetual quest to satisfy one's desires and accumulate pleasures but rather in the absence of suffering ([1818] 1998, p. 404).

Ill-being is necessarily more than not being able to satisfy one's preferences or enjoy coveted "goods", because while frustration may lead to situations of suffering, ill-being is not limited to frustration. Contrary to the frequently mentioned notion of well-being, ill-being has not really been explicitly conceptualized. Ill-being results above all from the tensions that run through an individual with social attributes caught up in contradictions between a norm and value system that imposes constraints on him or her and one or more "aggressive" stimuli of various natures and intensities.⁽⁸⁾ Ill-being is thus the result of complex interaction between three fundamental elements: one or several specific pressures, a socially characterized individual, a temporally and spatially situated society that, as such, has its own norm system. The different combinations between this interaction and the individual's representations of it produce an appropriate response or range of responses. This is what Elias is telling us in his way in *The Civilizing Process*: "But depending on the inner pressure, on the condition of society and the position of the individual within it, these [self-]constraints also produce peculiar tensions and disturbances in the conduct and drive economy of the individual." ([1939b] 1982, p. 243).

Ill-being incarnates moral or psychological suffering of a twofold nature: it is subjective, in that a given situation affects distinct but socially similar individuals to different degrees and the differential therefore seems to pertain exclusively to psychology;⁽⁹⁾ but it is also objective, in that it takes on identifiable forms and the many different ways it has of expressing itself and affecting different groups of people acquire measurable intensity and regularity. Because of this, ill-being cannot be reduced to its purely individual and psychological component; it also has eminently social content. Halbwachs reached the conclusion that "mental disorders and all conditions resembling them, vary through the effect of social influences and societal change [...]"

(8) Writes Roger Bastide: "We must add that men do not respond to mere external stimuli; they give meaning to those stimuli; that is, in contrast to animals, they react to symbols, not just signals." (1965, pp. 8-9).

(9) This claim would have to be examined critically, because in it, things considered

similar are linked at the cost of drastically simplifying the complexity of each individual. Not taking into account non-observed information, namely individual life-course, may lead to identifying as purely individual or psychological what is in fact due to incomplete or inadequate observation.

A mental illness [...] is a social fact that must be explained by social causes” (Halbwachs [1930] 2002, pp. 382-383, 1978). He reconciles the social and individual dimensions, observing that individual motives for suicide cannot be dissociated from social causes. However, taking into account the subjective dimension in no way means making a clean break from Durkheim’s thought: Halbwachs cites and analyzes insufficient social integration as the sole cause of suicide. Like Halbwachs, we are interested in the individual dimension of suffering as it is rooted in society.

The social dimension of ill-being involves the way emotion was constructed over history. The first effect of restraining violent impulses was to construct and modify taste, distaste, decency and modesty (Elias, [1939a] 1978). This example authorizes us to hypothesize that sources of suffering have been affected by societal changes over history. For example, the relatively recent change in the status of the child, by which it became the object of the parents’ affection (Ariès, 1960), suggests that suffering in case of separation from or death of a child is greater today than it was in the past. Histories and cultures specific to given societies logically lead to distinct social expressions of feelings, distinct “cultures of affect” (Le Breton, 1998), and this in turn means that the ill-being generated by one social system of affect is not the same as that generated by another. Halbwachs intuited this in the conclusion to an article published in 1947: “Love, hate, joy, pain, fear, anger were first felt and manifested together, in the form of collective reactions. It was in the groups we belonged to that we learned to express them, but also even to feel them [...] this means that each society, each nation, each period also leaves its mark on the sensitivities of its members.” The social dimension also manifests itself in tensions between an individual with social attributes –e.g., a gender, an age, a social and family status– and the society. These tensions can no longer be evacuated through violence as they were in the past. Writes Norbert Elias: “The battlefield is, in a sense, moved within. Part of the tensions and passions that were earlier directly released in the struggle of man and man, must now be worked out within the human being.” ([1939b] 1982, p. 242). For example, the exceedingly heavy mental load that employees in some companies have to bear may lead to depression and suicide (Ehrenberg, 1998). Going against internalized representations and socially constructed norms also generates suffering. The higher suicide rate among homosexual men and women (Verdier and Firdion, 2003; Lhomond and Surel-Cubizolles, 2003) is understandable in the framework of a society that exercises strong constraints to be heterosexual (Butler, 1990). Suffering arises from the perception of a discrepancy between internalized values and lived reality, a perception that leads to feelings of personal failure or insufficiency and loss of self-esteem. Halbwachs cites the example Rousseau gives in *Emile* of a healthy, happy man who receives a letter bearing grim tidings and is suddenly engulfed in deep moral pain: “He sinks into despair because one representation of the world has been brutally replaced by another, which calls for other reactions. But the previous reactions were also related to the idea he had of the external world and his place in it.” (Halbwachs [1930] 2002, p. 313, 1978). These necessarily social representations of the world, of

contingent events and of one's own place are at the core of ill-being, and they are dependent on the norms and values diffused and circulated by the society. If an individual's representation is modified by events, by a change in his or her situation, or by a change in social values, he or she may move from a state of well-being to one of ill-being. Though the death of persons close to us is not at all implicated in Freud's model of loss of self-esteem (Freud, 1915), it is not contradictory with what we have just said about representations. Halbwachs reminds us that death or separation from a loved one arithmetically reduces the "survivor's" network of relations, but more importantly, it isolates and cuts that person off from society, because in order to "remember" society, one has first to forget the deceased. "It is not isolation, but the sudden feeling of being alone that in all cases leads people to commit suicide." ([1930] 2002, p. 317, 1978). Insufficient social integration thus seems founded on feelings of loneliness—specifically, on the person's *representation* of his or her solitude—rather than on how isolated he or she objectively is.

Ill-being takes many forms

Suicide is the only expression of ill-being that Bentham referred to. Should we conclude that all people who do not commit suicide are perfectly happy, or at least that they experience more joy than pain? Suicide is not the only way of expressing one's ill-being; ill-being takes a variety of forms. Inquiring into the reasons why "Americans are so restless in the midst of their prosperity", Tocqueville noted that "complaints are made in France that the number of suicides increases; in America, suicide is rare but insanity is said to be more common there than anywhere else. These are all different symptoms of the same disease" ([1840] 1951, p. 186, 1863). Though Americans are not likely to commit suicide, this is not because they enjoy greater internal well-being, says Tocqueville. In condemning the act of suicide, religion goes a long way to eliminating it as a possibility, but does not thereby eliminate what may make life unbearable to Americans. Ill-being expresses itself in another way, over which religion has no direct sway: mental illness.

The concept of ill-being enables us to include suicide in a set of other states that reflect some degree of distress, and it is heuristically useful in understanding gendered behavior. We can usefully complexify suicide and make it more intelligible by taking into account attempted suicides, which are more numerous than suicides and more likely to be enacted by women. Three-quarters of all suicides are men, whereas twice as many women as men attempt suicide (Davidson, 1986; Badeyan, Parayre, Mouquet *et al.*, 2001; Mouquet, Bellamy and Carasco, 2006). There are fifteen times more suicide attempts than suicides, a point confirming that the two are incommensurable, that they are separate phenomena. It has often been opined that the difference in male and female suicide levels is due to the fact that women are likely to use inefficient means, which are also less violent. But in that case, would

it not be more judicious to ask why women systematically choose such means?⁽¹⁰⁾

Above all, though suicide attempts do include “botched” suicides, most of them actually represent a social phenomenon that is different from suicide. Bothered by the contradiction between the higher rate of male suicides and the higher rate of female attempted suicides, Halbwachs ultimately excluded attempted suicide from his definition of suicide: “Nothing proves intention, nothing proves the victim had known that his act had to produce death, if not the indisputable fact that he carried it out to the end.” ([1930] 2002, p. 66, 1978). Indeed, attempted suicide is more a desperate call for help against ill-being that has become invasive than an intention to end one’s life. They correspond less to a rejection of life than “an intense need to ‘live differently’, even if it means risking one’s life to make that need understood” (Davidson, 1986, p. 152). While suicide is in most cases a desperate act committed against self, attempted suicide expresses a hope aimed in the direction of others.⁽¹¹⁾ However, both behaviors are undeniably expressions of distress, suffering, ill-being. Suicide and attempted suicide may be thought of as two distinct expressions of ill-being, the first primarily male, the second female. If female ill-being is more likely to be expressed through attempted suicide than suicide, this can be seen as the internalization of a gendered habitus. This would also explain women’s loathing for violent means and, “conversely”, men’s attraction to them.

We see that ill-being is not observed directly but through manifestations that take different forms. The origin and intensity of individual suffering is legion; it is therefore not surprising that responses to it are equally diverse: suicide, suicidal behavior, alcohol dependence, depression, feelings of solitude, bulimia, anorexia, various non-degenerative mental illnesses, etc.⁽¹²⁾ Econometricians call phenomena such as this, which cannot be observed directly, “latent variables”. They can only be approached indirectly, by way of their visible manifestations, which in turn are measurable, segmented indicators of a larger phenomenon. Similarly, we are more comfortable defining ill-being as an inclusive or generic concept, like social hierarchy. Ill-being cannot be reduced to a continuous variable that progresses linearly from a lowest to a highest degree, or, to cite our examples, from a feeling of loneliness to suicide by way of intermediate stages such as alcohol dependence and

(10) Gender differences in types of suicide are also due to unequal access to the means for committing those types of suicide. Men have readier access to fire arms by occupation (guard, gendarme, policeman, military personnel) or leisure activity (hunting, shooting). Women, who are more likely to be depressed than men, have readier access to tranquilizers, the first means of attempting suicide for both sexes (Davidson and Philippe, 1986).

(11) This statement must be qualified because “genuinely botched suicides” figure

among suicide attempts, while suicide attempts that went wrong in that they were not meant to work and vindictive suicides (failed love affairs, vengeance or “emotional blackmail”), which are also aimed toward the outside world, figure among completed suicides (Baudelot and Establet, 2006).

(12) It would be useful to further develop sociological investigation of mental illness, particularly the long-standing dichotomy between psychosis and neurosis (Bastide, 1965).

depression. It is instead a discrete variable whose terms may be interpenetrated (suicide and depression, loneliness and alcohol dependence) or unrelated to each other (anorexia and alcohol dependence) but which is nonetheless characterized by degrees of intensity. Our understanding here is that social construction of gender and gendered values induce individuals to produce gender-specific responses to the various events and situations they experience. In other words, gender dispositions or habitus tend to orient the way men and women represent their situations and therefore to produce responses adapted to individual incorporation of gender identity.

Gender-specific expressions of ill-being

It is tempting to transpose Tocqueville's example of Americans to the case of men and women. Suicide is primarily male, but women are more likely to attempt suicide; likewise, men have a penchant for alcohol while women are more likely to be depressive. This observation acquires greater generality if we consider men's higher mortality rate and women's higher morbidity rate (Aïach, 2001). And it makes it difficult to defend the sweeping statement that women experience greater well-being –an idea based on their observed immunity to suicide. The apparent contradiction between different ways of expressing ill-being in fact indicates that each way has its specificities, one of which is gender. This means that if we focus exclusively on one way of expressing ill-being and ignore the others, we risk misinterpreting our results. Only by simultaneously studying different ways of expressing ill-being can we satisfactorily apprehend disparities in ill-being between the sexes and draw relevant conclusions about them. A single type of expression, such as suicide, will inform us on that particular indicator rather than on ill-being in general (Aneshensel, Rutter and Lachenbruch, 1991).

Analyzing gender differences also requires studying several ways of expressing ill-being, some traditionally male, such as suicide and alcohol dependence, others primarily female, such as depression and being at severe risk for suicide (Aneshensel, Rutter and Lachenbruch, 1991; Horwitz, White and Howell-White, 1996; Simon, 2002; Umberson, Wortman and Kessler, 1992; Umberson, Chen, House *et al.*, 1996). Setting these different forms of ill-being alongside one other also enables us to reject explanations that naturalize women's greater depressiveness –explanations induced by observation convergence and repetition. We need to maintain some critical distance when examining statistical statements of this kind, which tend to reify observations into statements like “The female constitution is more delicate”, thus confusing cause and effect. In fact, what Lovell and Fuhrer's review of the literature (1996) clearly shows is that women are more likely to have affective and anxiety disorders *and* that men are more likely to behave antisocially and have disorders linked to alcohol or drug consumption.

In light of these facts, we use the concept of ill-being, which allows for bringing together the various ways in which it is expressed (indeed, any

conclusions drawn from *separately* studying one or another of these ways of expressing ill-being would be biased), to reexamine conclusions about women being “overprotected” from suicide and men benefiting more than women from being married. Taking inspiration from Simon’s hypotheses (2002) in an article entitled “Revisiting the Relationship Among Gender, Marital Status, and Mental Health”, our study of gender differences vis-à-vis ill-being aims to provide answers to the following points: 1) If the diverse ways of expressing ill-being are fundamentally gender-specific, then women should have higher levels of suicidal behavior and depression and men should have higher suicide rates and more frequent problems with alcohol, and these regularities should be observed regardless of age or family situation; 2) Simultaneously examining our four ill-being indicators allows for testing the validity of the concept of marital and family integration: individuals living together as a couple, especially those with children, should come out furthest from ill-being, regardless of indicator; 3) If men benefit more than women from being married, then the married/single difference should be sharper for men.

Data, indicators, methods

Given the nature of the available data, we chose to study four ways of expressing ill-being. Suicide rates come from INSERM cause-of-death records for 2003. Serious risk for suicide was estimated using INPES’ [Institut national de prévention et d’éducation pour la santé] 2005 Baromètre Santé survey. The CES-D (short self-report) international scale for measuring depression symptoms and the DETA alcohol consumption questionnaire were introduced into INSEE’s most recent Santé survey (2002-2003) to determine depressiveness and excessive alcohol consumption scores.

The data on suicide available at INSERM’s Centre d’Épidémiologie sur les Causes Médicales de Décès (CépiDc) are from two amalgamated administrative sources: death certificates and the public records office. The base contains approximately 11,000 suicides, out of 500,000 annual deaths. The quality of suicide statistics has often been criticized, and some researchers have deemed this argument incontrovertible proof that Durkheim’s results were wrong (Douglas, 1967; Baechler, 1975). The claim is that suicide statistics only inform us on national procedures for counting deaths by cause. Bias may occur during the process of recording deaths, particularly if the certifying physician says nothing about the intentionality of the act or the forensic unit does not communicate the conclusions of its autopsy report to the statistics office. While death by suicide is usually underestimated by between 20% to 25%, this does not significantly modify socio-demographic distributions, and this in turn means reliable social group comparisons can be made (Baudelot and Establet, [1984] 2002; Jouglu, Pequignot, Chappert *et al.*, 2002). Cause-of-death statistics were not originally meant to be used in demography, epidemiology, or sociology research. We have therefore only taken into account suicide rates by marital status and age for each gender. Following

Durkheim, we have calculated the coefficient of aggravation for single persons relative to married persons for each sex.

Suicide statistics may be riddled with problems, but at least they exist. There are no such statistics for suicide attempts; the information is not collected in France. By extrapolating from data provided by physicians and the hospital system, we estimated that in 2002, the system was called on to intervene in 195,000 cases of attempted suicide. The number of attempts that did not involve any contact with the health care system is of course unknown. General population surveys show that 8% of the French population have attempted suicide at some point in their life. These painful past events may very well be under-reported. Though we cannot dismiss this possibility, certain indications diminish its importance. The DREES-CCOMS Santé mentale en population générale survey and the INPES Baromètre Santé found relatively similar prevalence rates (Mouquet, Bellamy and Carasco, 2006). Moreover, according to Baromètre santé 2005, 0.4% of individuals aged 18 and over stated they had attempted suicide in the preceding year –the equivalent of 190,000 attempts, approximately the same figure as the one recorded by the health care system. The Baromètre santé surveyed approximately 30,500 persons (INPES, 2006) and it contains a great deal of information on health in the general population, including a section on mental health. Respondent numbers were too low to allow for studying attempted suicide alone, so we focused on high suicide risk (HSR), defined here either as an affirmative answer to the question “Have you attempted to commit suicide in the past year?” or affirmative answers to both the following questions: “Have you thought of committing suicide in the last 12 months?” and “Have you tried to commit suicide at some point in your life?” (Bellamy, Roelandt and Caria, 2004). Doctors and psychiatrists are generally of the opinion that one suicide attempt sharply increases the likelihood of another and of completed suicide. This observation, often based on personal medical practice, seems to be confirmed statistically: of a cohort of 300 individuals hospitalized for attempted suicide, 7% had killed themselves five years later and 35% had made another attempt to do so (Beautrais, 2004).

Data on depression and alcohol dependence are from INSEE’s Enquête santé 2002-2003. This survey is conducted once every ten years and is extremely useful for research on household and individual health. More than 16,000 households comprising a total of 40,000 individuals were interviewed. Contrary to earlier waves of the same survey, adults capable of responding were interviewed individually. The sections on depression and alcohol were self-administered. Certain 2002-2003 survey questions allow for locating answers on internationally validated score scales used in epidemiological studies.

The various ways of measuring depression in a general population survey do not generally coincide. Collecting whether respondent takes prescription anti-depressants is not a rigorous approach to depression as a medical condition, since one-quarter of depressives in France are not treated for the condition (Morin, 2007). The French Agence du médicament specifies that one

third of anti-depressants are not prescribed in connection with any clear-cut depressive episode (Amar and Balsan, 2004). Moreover, according to the CREDES [public health consulting] 1996-1997 Santé et protection sociale survey, the prevalence of depression as declared by individuals not only does not coincide with the figure found by the MINI questionnaire⁽¹³⁾ but results in a lower figure (Le Pape and Lecomte, 1999). We opted to use the CES-D scale to measure depressiveness indirectly;⁽¹⁴⁾ this enabled us to reduce the uncertainty due to mental health question response bias. It is often said that women more readily state they are mentally ill than men. If this were true, then the differences found would be more a matter of response bias than reality. Using the CES-D depressiveness scale instead of spontaneous “am depressive” or “have depressive episodes” statements narrows the gap between male and female prevalence of depression but attests that women are still twice as likely to be depressed than men (Leroux and Morin, 2006). However, opinions are divided on the probability of gender-specific response bias. Researchers using a specific survey question protocol have concluded that both sexes tend to understate health problems, specifically mental health problems, apparently not so much out of fear of others’ implicit judgment of them as poor knowledge about the disorders themselves.⁽¹⁵⁾ Contrary to the common belief, women are even slightly more likely than men to understate mental disorders (Macintyre, Ford and Hunt, 1999).

The same questions arise in measuring alcohol abuse. Consumption level and type of alcoholic beverage are strongly correlated with age. Two-thirds of persons 65 or older drink some alcoholic beverage daily, while young people consume greater quantities of strong alcoholic beverages at weekend parties

(13) Using the MINI international neuro-psychiatric interview, a depressiveness scale can be established on the basis of a list of symptoms. The MINI represents an alternative to the CES-D.

(14) The CES-D (Center for Epidemiological Study of Depression) Scale includes 20 questions that cover most of the criteria used to diagnose depression (sadness, fatigue, appetite or sleep disorders, feelings of inferiority, difficulty concentrating), the aim being to spot pre-depressive symptoms and assess how severe they are. Since depression is not diagnosed by physicians, the understanding here is that this scale provides an indirect measure of depression. Still, for the sake of convenience, we will use the two terms—depression and depressiveness—interchangeably in the text. Survey questions bear on previous week, so depressiveness is measured at the time of the survey (see Appendix). Scores range from 0 for no pre-depressive symptoms to 60 for major depression. It is generally recom-

mended to consider two graduated thresholds non-differentiated by gender: 17 or above constitutes depressive symptomatology and 23 or above outright depression symptoms (Husaini, Neff, Harrington *et al.*, 1980). We chose to use the higher threshold, keeping in mind that threshold chosen mechanically modifies number of depressive persons but not the characteristics of the group thus identified.

(15) Some respondents in the 2002-2003 Santé survey agreed to take a medical examination. Comparing the data shows that there is overall understating of health problems such as obesity, high blood pressure and high cholesterol. In a society where slimness is worshiped—an attitude that affects the female sex in particular—women are more likely than men to underestimate their weight. Still, gender does not introduce systematic bias: under-reporting of high blood pressure and high cholesterol is due above all to lack of knowledge about these health problems (Dauphinot, Naudin and Guéguen *et al.*, 2006).

and other outings. By World Health Organization criteria, regular consumption of alcohol is not in itself problematic as long as it remains moderate.⁽¹⁶⁾ Consumption is considered dangerous when it exceeds weekly recommended limits and/or involves relatively frequent drunkenness. In the short term, excessive alcohol consumption increases accident risk and risk of violent behavior; in the long term, risk for dependence and premature death. Alcohol dependence can be measured with the DETA⁽¹⁷⁾ questionnaire by way of four questions: “In the last 12 months, 1) have you felt the need to reduce your alcohol consumption? 2) has your family commented on your alcohol consumption? 3) has it seemed to you that you were drinking too much? 4) have you needed a drink in the morning to feel in shape?” Clinicians are currently of the opinion that individuals who answer “yes” to at least two of these questions are drinking too much and that their practice may induce pathologies. In a French study of hospital patients and outpatients, DETA questionnaire answers were compared with physician recommendations: according to the doctor, 18% of hospitalized men and 19.5% of hospitalized women had an alcohol problem, whereas the DETA result was negative. The disparity is even greater when private-sector doctors are consulted. The DETA usually bears on entire life span; it may therefore produce positives for former alcohol-dependents who were no longer drinking at the time of the survey. This would explain at least in part the non-congruence between patient statements and doctor’s recommendations (Canoui-Poitrine, Mouquet and Com-Ruelle, 2005). We have avoided that bias here since the year-long time-span was clearly indicated in 2002-2003 Santé survey questions.

Statistical models and endogeneity tests

Contrary to the suicide data, logistic multivariate analysis can be run on the suicidal risk, depression and alcohol dependence data. Our model variables are age, sex, household type, socio-economic position (educational attainment, occupational status, household income), health (disability or handicap), and major events in childhood and the previous year, given the demonstrated connection between such events and depressive states (Menahem, 1992). Though the two sources for this information do not perfectly correspond, the information collected from them is still similar enough to allow for comparing the different ill-being indicators. The logistic models for each risk simultaneously evaluate men’s and women’s risk levels by crossing each independent variable with sex, thereby bringing to light possible contradictory effects. This method allows for rigorously assessing the significance of differences between “men” and “women” parameters.

(16) Moderate is an average of three glasses a day for men, two for women.

(17) The DETA (Diminuer, entourage,

trop, alcool) is a French variation on the American clinical test known as CAGE (Cut down, annoyed, guilty, eye-opener).

Statistically non-observable variables such as physical appearance are likely to affect the probability of living with an intimate partner and of experiencing relatively intense ill-being. The additional ill-being of persons living alone would then be due in part to such non-observable variables, and this would introduce bias into logistic coefficients. To avoid endogeneity bias and correctly estimate coefficients, we generally used models that simultaneously evaluate two equations: probability of living with someone and probability of experiencing ill-being. From the non-significance of correlations between the residuals of these two equations we conclude that there is no endogeneity bias.⁽¹⁸⁾ The international literature teaches that benefits from marriage come from the protection due to this union rather than marital selection. According to Anglo-Saxon studies based on longitudinal data, marital selection is limited and based exclusively on mental health. A study of a cohort of young adults brought to light that depression as such does not influence the probability of getting married. Alcoholics, however, are more likely to fail on the marriage market (Horwitz and White, 1991).⁽¹⁹⁾

Apparent contradictions among ways of expressing ill-being

In 2003 in France, the suicide rate for women was one-third what it was for men, *i.e.*, respectively 9.2 as against 27.5 suicides for 100,000 inhabitants. The regularity of men's higher rates throughout the life cycle regardless of marital status confirms, if ever confirmation were needed, that suicide is first and foremost a male way of expressing ill-being (Table 1). It could be objected that what is perceived in this discrepancy is actually the benefit of having –and having to take care of– children: women are still fundamentally in charge of them. Durkheim was able to show, albeit on the basis of rather shaky data, that the presence of children provided decisive protection against suicide ([1897] 1997, pp. 207-208, 1951); from this he concluded that “the family is the essential factor in the immunity of married person; that is, the family as the whole group of parents and children”. Halbwachs, using data for Soviet Russia, refined this by making it a function of number of children: “In sum, the more children the married man or woman has, the woman especially, the better protected against suicide.” ([1930], 2002, p. 178, 1978). Unfortunately, these observations cannot be confirmed for our time because we do not have suitable data (we shall return to this point). However, female relative immunity to suicide is already observable among adolescent girls and young

(18) Of all the bivariate probit models using instrumental-variable estimators that we tested, only equations between living with someone and female alcohol dependence showed a moderate correlation, significant at the 10% threshold.

(19) Though the social conditions of

alcohol consumption are not the same in France as in the United States (primarily for cultural reasons), American studies are relevant here because alcohol dependence constitutes an expression of individual ill-being that is not socially valued in either France or the United States.

women aged 15 to 24, most of whom have not yet had children. This would seem to prove that women’s protection is not due solely to the presence of children, that there are other causes (Table 1).

Baudelot and Establet’s appealing hypothesis is based on the understanding that women are more fully integrated into the family. They extended this hypothesis, putting forward a single theory based on Durkheim’s concept of integration: “The degree to which an individual is protected from suicide is a function of the number and closeness of relations he or she develops within the family circle. With this hypothesis we redefine integration and add the following sub-hypothesis: sex and age may be thought of as factors of integration into the family.” (1984, p. 101). Here again we cannot statistically test this hypothesis because we do not have the necessary information on the family status of suicide victims.

TABLE 1. – *Suicide rates by marital status and age (per 100,000 inhabitants)*

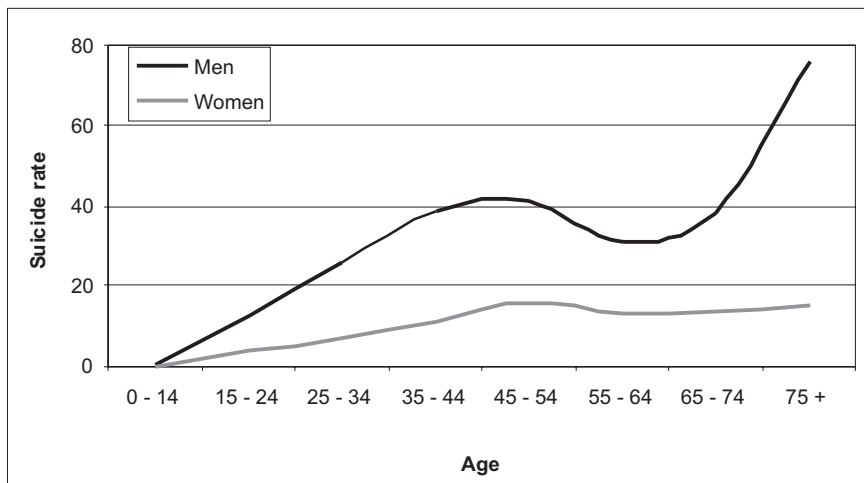
| | Single | | Married | | Widowed | | Divorced | |
|-------|--------|------|---------|------|---------|------|----------|------|
| | M | F | M | F | M | F | M | F |
| 15-24 | 12.4 | 3.6 | 17.5 | 5.0 | - | - | - | - |
| 25-34 | 30.0 | 8.9 | 15.2 | 3.7 | 310.5 | 28.9 | 38.7 | 15.4 |
| 35-44 | 49.4 | 16.5 | 27.4 | 6.9 | 130.6 | 30.4 | 76.4 | 22.3 |
| 45-54 | 58.3 | 20.8 | 30.7 | 11.3 | 98.6 | 33.6 | 75.3 | 26.6 |
| 55-64 | 55.9 | 16.6 | 23.0 | 10.4 | 87.5 | 17.4 | 54.8 | 22.3 |
| 65-74 | 66.7 | 16.1 | 29.2 | 10.0 | 90.7 | 17.4 | 61.4 | 23.4 |

Source: Centre d’Épidémiologie sur les Causes Médicales de Décès (CépiDc, INSERM) deaths in 2003.

Still, if we agree to think of suicide as one category of a wider phenomenon –what we are calling ill-being– then we can expect the same causes to produce the same effects. With this established, it becomes hard to explain the meaning of the apparent contradictions between the lower number of female suicides (Figure 2) and the greater number of female suicide attempts (greater risk for suicide) and greater female incidence of depression (Figure 3). This in turn makes it difficult to substantiate Baudelot and Establet’s hypothesis as formulated because we would be forced to conclude that the benefits accruing to interaction with the family network apply only to the fatal act, not to attempted suicide, being at high risk for suicide, or depression –all states that are likely to precede suicide (Davidson and Philippe, 1986; Lemperière, 2000). In other words, interactions with the extended family cannot both protect individuals from the most radical form of ill-being *and* prove ineffective against –or actually aggravate– types of ill-being that do not involve loss of life. If having relatively high numbers of interactions with one’s extended family protects people from one way of expressing ill-being (suicide), why

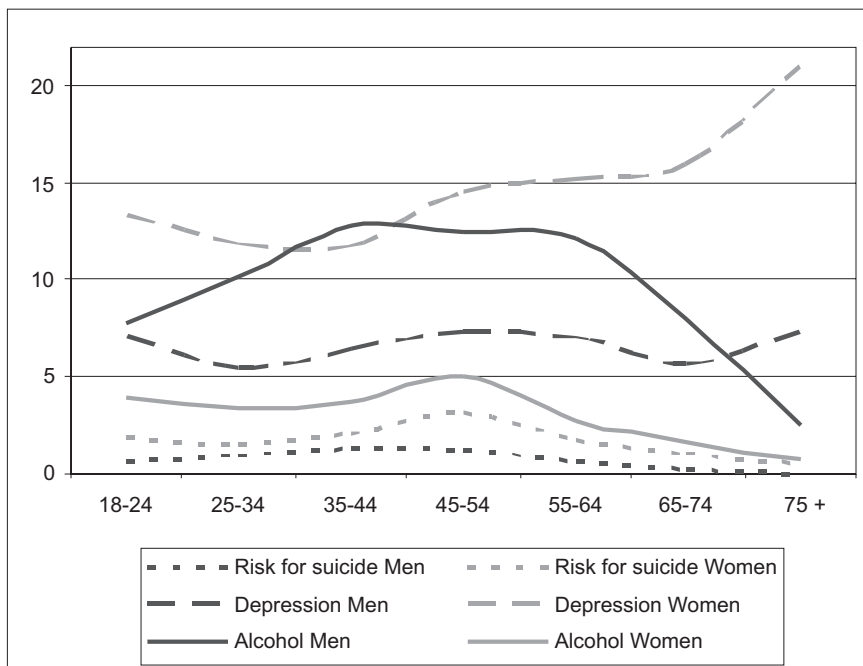
wouldn't it protect them from other ways as well? Moreover, the hypothesis of family interaction cannot resolve the paradox of a lower suicide rate for women and higher prevalence of depression. In reality, most of the differences between the sexes for a given way of expressing ill-being are not differences in degree of integration but have to do instead with the particular ways each sex expresses ill-being. Nonetheless, researchers have convincingly demonstrated that "supportive" relationships (*i.e.*, relations of support and trust between the individual and his/her parents, friends, relatives) do moderate psychological distress. They point out that without the typically female dense relational network, women would experience still higher levels of depression. Conversely, they note that strained relationships –regularly taking care of dependent parents, for example– aggravate depression levels (Umberson, Chen, House *et al.*, 1996). This leads us to think that supportive relationships with close relatives do work to temper ill-being, but not enough to overcome differences between men and women with respect to depression and suicide.

FIGURE 2. – *Male and female suicide rates by age* (for 100,000)



Source: Centre d'Épidémiologie sur les Causes Médicales de Décès (CépiDc, INSERM), deaths in 2003. Our graph.

FIGURE 3. – *High suicide risk, depression and alcohol dependence by age (%)*



Source: INPES's Baromètre Santé 2005 for suicide risk, INSEE's Enquête Santé 2002-2003 for depression and alcohol dependence. Our calculations.

Frame: Individuals in France aged 18 and over.

What suicide curves by gender reveal first and foremost are gender differences. After the effervescence of the first few years of retirement (Delbès and Gaymu, 2004), men's suicide rates rise considerably while women's stagnate. These facts should be interpreted thus: in that period of life, men have to cope with a problem of what to do with their time, and this pushes them in the direction of suicide, whereas women, likewise coping with aging, are not penalized by this, at least not in connection with suicide. This phenomenon is hard to understand if we do not consider indicators other than suicide. Already shaken by the demonetization of their social status and the loss of work relationships in their social network, do retired men find it difficult to reconcile their male representations of virility with their declining intellectual and physical capabilities and loss of their power attributes or work responsibilities? If so, then why aren't women, for example, who are more socially dependent on their bodily appearance than men and confronted in that period of life with their declining physical attractiveness, more likely than they actually are to commit suicide at that age?

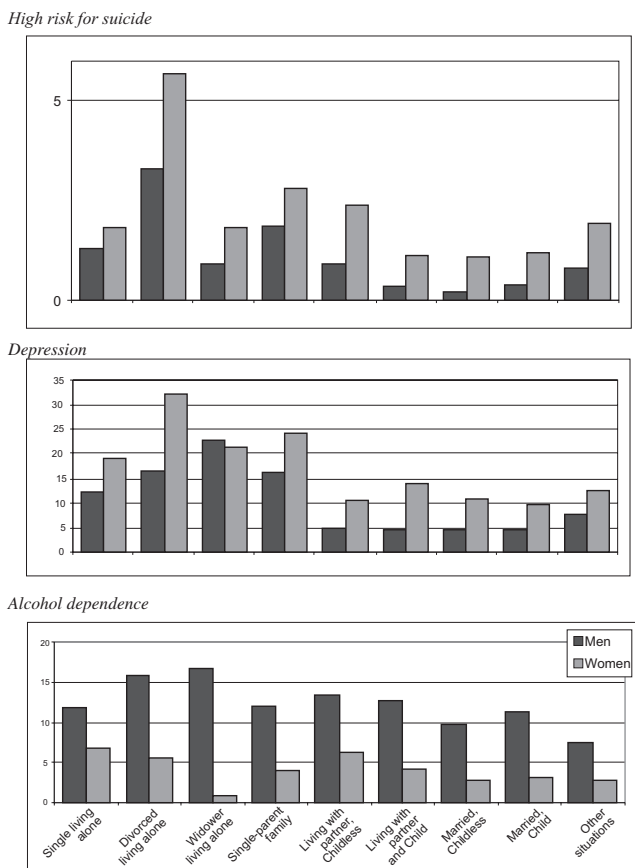
In fact, while female suicide stagnates over age 45, female depression is simultaneously gaining ground (Figure 3). Moreover, the striking similarity between the sexes' risk-for-suicide curves –a peak between 45 and 54, followed by a decline– seems to indicate that the two indicators are of the same nature. It should also be recalled that the peak for female suicide is reached relatively early –ages 45 to 54– then plateaus out. At this moment in women's lives, there is indeed an event or, in all likelihood, a series of events that works to destabilize them. This age often corresponds to the departure of children from the parental home, the arrival of menopause, consciousness that their powers of seduction have lost value.

For men, alcoholic dependence culminates between ages 35 and 64, then falls continuously. This might represent heterogeneous phenomena: young men's alcoholism, originating in sociability or “partying” or due to the influence of peers (all of this typically linked to the male role), plus older men's expressing ill-being through alcohol abuse. The fall in alcohol dependence among older men may seem surprising given their regular alcohol consumption. Clearly it is not biased by increased social isolation because not including the DETA question on family circle's comments does not bring about a change in age profile. Moderate alcohol consumption, even daily, is not viewed medically as a dangerous practice. Epidemiological studies have even found that moderate daily consumption is beneficial for cardiovascular health. The resolute fall in alcohol dependence over age 65 could also result from a selection effect, however, since one out of two deaths attributed to alcohol occurs under age 65. The other two indicators are harder to read on the basis of age alone: male depression remains stable overall across age spans; male risk for suicide is extremely low and comes very close to zero for very old men, confirming once again the dissociation between this phenomenon and suicide.

Ill-being curves are not at all the same, but it could hardly be otherwise, since they confirm the specificities of each way of expressing ill-being, specificities resulting from multiple complex combinations between different pressures of unequal intensity and an individual whose social characteristics orient his/her behavior and his/her perception of negative stimuli. Whatever the age, women are more frequently at risk for suicidal behavior and more likely to be depressed, whereas men are more dependent on alcohol and more likely to kill themselves.

These results do not conceal a problem of family structure, as they are confirmed on the basis of various household types. Regardless of family structure, women are much more likely to be depressive or at risk for suicide while men are more likely to be alcohol-dependent, the only exception being depression among widowers living alone, for whom the predicted difference between men and women is not observed (Figure 4). These results also withstand multivariate analysis. When other characteristics are controlled for, women are more than twice as likely than men to be at high risk for suicide, twice as likely to be depressive and only one-fifth as likely to be alcohol-dependent (Table 3).

FIGURE 4. – *High risk for suicide, depression, alcohol dependence (%)*



Source: INPES’s Baromètre Santé 2005 for RSG and INSEE’s Enquête Santé 2002-2003 for depression and alcohol dependence. Our calculations.

Frame: Individuals In France aged 18 and other.

This set of results supports our hypothesis that ill-being derives from the social construction of gender. That hypothesis allows us to shrink the contradiction between the preponderance of suicide and alcohol dependence among men and the preponderance of suicide attempts and depression among women. Social construction of gender, then, is what causes the differences observed between the sexes in ways of expressing ill-being. Men can be thought of as emotionally retentive, aggressive, more likely to externalize ill-being through violence, including suicide, more likely to violate the law, take deliberate risks (Peretti-Wattel, 2003), abuse alcohol and drugs, but also more likely to realize the social vocation of assuming the responsibilities of head of household or “breadwinner”, and thus in general to behave in ways

that involve representations of virility. 85% of persons accused of various offenses and theft from 1950 to 1992 in France were men (Robert, Aubusson de Cavarlay, Pottier *et al.*, 1994, p. 65); nearly all persons accused of sexual violence are men; in 84% of physical brutality cases, and 93% of attempted murders in France the accused are men (Jaspard and the ENVEFF research team, 2001). Similarly, 94% of offenders and 90% of murderers in the United States are men. Women are in charge of running the house, taking care of children and relationships; they are associated with the qualities of gentleness, delicacy and sensitivity, expression of feelings, self-realization through successful family life, *i.e.*, living with a man and having children (see Belotti, 1974; Singly, 1987; Bourdieu, 1998; Baudelot, Gollac, Bessières *et al.*, 2003); they less “spontaneously” use violence and the violence they do use is more likely to be verbal than physical (Choquet, Menke, Ledoux *et al.*, 1993); women are more likely to have psychosomatic reactions and to experience depression (Braconnier, 1996, p. 96). Ehrenberg adds: “Alcoholism is the main manifestation of male depression. Women develop symptoms; men, behaviors.” (1998, p. 178). Slow and continuous inculcation of these values defines each gender during childhood (Belotti, 1974) and later comes to structure people’s identities and their most intimate behavior. It is therefore hardly surprising that reactions to various situations and aggressive stimuli take forms adapted to the values and attitudes incorporated by each gender. Margaret Mead observed just such gender-specific value construction in the South Sea Islands: “Originally two variations of human temperament, a hatred of fear or willingness to display fear, they have been socially translated into inalienable aspects of the personalities of the two sexes. And to that defined sex-personality every child will be educated: if a boy, to suppress fear, if a girl, to show it.” (Mead [1935] 2001, p. 268). Individuals’ ill-being is expressed through behavior that is socially consistent with the gender they belong to. While divergences among these indicators show the singularities of each way of expressing ill-being and reveal specific groups, convergences validate conclusions that can be generalized to individual ill-being altogether.

Gender-differentiated benefits from marriage and the weakening of the marriage institution

Ever since Gove’s studies in the 1970s and early 1980s, the question of the differential benefits of marriage has dominated the field of sociological research into gender differences as they relate to mental health. Compared to non-married individuals of both sexes, married men suffer less from mental disease than married women. Conversely, single women are less likely to have psychological problems than single men. Marriage has therefore been understood to protect men’s mental health while being a burden for women (Gove, 1972). This difference was understood to be due to the traditional male and female roles in marital society. The generally demeaning domestic role, which (still) falls to women, plus working women’s relatively low satisfaction

with their jobs, were understood by Gove and Tudor (1973) to cause women's greater degree of frustration. In addition to the authors' questionable choice of neuroses –*i.e.*, what women are likely to suffer from– as the only possible approximation of mental health (Dohrenwend and Dohrenwend, 1976), their theory is based on an analysis of gendered social relations that dates from the early 1970s; *i.e.*, a period prior to the rise in female wage labor and the current weakening of the marriage institution. The claim that marriage was favorable to men and unfavorable to women was not really called into question much until recently, probably because it resonated with our sociological knowledge of inequality between men and women (Williams, 2003).

But the family has undergone striking changes since the late 1960s: development of cohabitation, rise in the ages at which people get married for the first time and have their first child, increase in number of children born outside marriage, increase in divorce rates correlative to the institution of divorce by mutual consent in France, etc. These changes must have affected how the benefits of marital union are distributed between the couple members. Durkheim already showed that “marriage is more favorable to the wife the more widely practiced divorce is” ([1897] 1997, p. 302, 1951). Moreover, the spread of female wage labor helped redefine power relations between spouses. Marriage no longer exercises the same constraints, particularly not on women, because it is only one –though of course the most likely– type of union among others currently practiced in France (PACS [Pacte Civil de Solidarité], cohabitation), and when people do marry they know the tie can be broken. Because the marriage institution has grown weaker, the protection from suicide due to marriage has also been affected, though it has not disappeared (Besnard, 1997; Surault, 1995). Recent Anglo-Saxon studies on depression and excessive alcohol consumption show that marriage has a positive influence on mental health for both sexes (Ross, 1995; Horwitz, White and Howell-White, 1996; Simon, 2002; Williams, 2003). This result suggests the relevance of reexamining the hypothesis that men stand to gain more by marriage.

Given the profound changes in the family, analysis in terms of marital status may seem somewhat passé. The status categories have become much more heterogeneous. “Single” includes people who have never cohabited, cohabiting persons, and separateds; “married” includes couples with or without children; “divorced” includes people living alone or single-parent heads of household as well as persons who are now part of a different couple. In health terms, married couples living with or without children are usually most favored, while single mothers seem particularly disadvantaged. The effect of marital status on health thus depends not so much on legal status as type of household that status really corresponds to (Hughes and Waite, 2002). Unfortunately, our suicide data only include legal marital status. For the other ways of expressing ill-being, information on cohabitation, presence of children, and new family types (cohabitation, single-parent, etc.) is available.

Who benefits from the marriage tie?

The study of suicide is what first shed light on the marriage benefit differential between men and women, though legal status does not allow for distinguishing between what pertains to marriage *per se* and what to conjugal and family life taken together. As Durkheim already observed in the nineteenth century, with the exception of early marriages, married persons are less likely to commit suicide than non-married ones (Table 2). Widowed and divorced persons do not seem to benefit from their status of former marrieds: their suicide aggravation coefficients are higher than for single persons. Moreover, in our time widowers are more likely than any other category to take their own lives (Besnard, 1997). Despite the weakening of the marriage institution, marriage therefore still protects from suicide. But does this beneficial effect still pertain exclusively to men?

Durkheim's conclusion in *Suicide* that men are the ones to benefit from marriage has to be qualified a century later. First, it is only at age 55 and over that men's suicide aggravation coefficient rises above women's (Table 2). Between ages 25 and 44, *i.e.*, the procreation years, being a single woman actually seems less favorable than being a single man compared to spouses of both sexes. As society sees it (and this includes how women themselves see it), realizing oneself as a woman means having children. Though the correspondence between being unmarried and living alone has loosened due to the ways marriage has changed, it is likely that what comes through here is the social pressure on women who have not yet realized their social destiny of motherhood. Once the biological age of procreation is over, being single does not seem as difficult or painful for women. Moreover, while widowers have a higher suicide aggravation coefficient than widows, the male advantage from marriage no longer holds for divorced people. Contrary to what Besnard (1997) observed between 1981 and 1993, divorce now increases the likelihood that women will commit suicide, as much if not more than the likelihood that men will, compared to married persons. The fact that women usually obtain custody of the children and may therefore be thought of as more strongly integrated into the family does not seem enough to compensate for the negative effects of divorce. As Durkheim sensed, the instituting of divorce strengthened protection for married women. But it also made people in the newly instated "divorced" category more vulnerable. To what degree do the other types of ill-being confirm these preliminary results on suicide? As we shall see, the destabilizing of the marriage institution is cause to reconsider the claim that men benefit more from marriage.

TABLE 2. – *Coefficients of aggravation for suicide for spouses of each sex*

| | Single | | Widowed | | Divorced | |
|-------|--------|-----|---------|-----|----------|-----|
| | M | F | M | F | M | F |
| 15-24 | 0.7 | 0.7 | - | - | - | - |
| 25-34 | 2.0 | 2.4 | 20.4 | 7.8 | 2.6 | 4.2 |
| 35-44 | 1.8 | 2.4 | 4.8 | 4.4 | 2.8 | 3.2 |
| 45-54 | 1.9 | 1.8 | 3.2 | 3.0 | 2.5 | 2.4 |
| 55-64 | 2.4 | 1.6 | 3.8 | 1.7 | 2.4 | 2.1 |
| 65-74 | 2.3 | 1.6 | 3.1 | 1.7 | 2.1 | 2.3 |

Source: Centre d'Épidémiologie sur les Causes Médicales de Décès (CépiDc, INSERM), deaths in 2003.

Reading: Single men aged 25 to 34 are twice as likely to commit suicide than married men of the same age.

The benefit for men of living with an intimate partner

“All else kept equal” procedures neutralize discrepancies attributable to gender for the various ways of expressing ill-being. They thus enable us to focus on gender differences by household type without having to deal with the initial discrepancy.⁽²⁰⁾ With other characteristics controlled for,⁽²¹⁾ individuals living alone, be they single, widowed or divorced, are particularly exposed to ill-being, namely suicidal tendencies and depression (Table 3). Gains are observable for both men and women belonging to a couple.

As with suicide, the possible benefits of marriage are lost when marriage comes to an end: formerly married persons, now either widowed or divorced, are not any more protected from ill-being than single persons who have never been married.

(20) In this section we do a more detailed reading of gender differences for each type of household (Table 3). The difficulty of interpreting the table arises from the dual reading. *Columns* represent the three ways of expressing ill-being. For each sex, each type of household was compared to “married with children” (the reference situation). For example, single men are 4.2 times ($e^{1.44}$) more likely to be at high risk for suicide than married men with children. Likewise, single women are twice as likely ($e^{0.68}$) to be at high risk for suicide than married women with children. These results show that both sexes benefit by being married (compared to being single). However, given the

difference in relative risk between the sexes (odds ratios), men benefit more than women. Reading male and female parameters by *row* allows for assessing interaction between type of household and sex. For high risk for suicide, the difference between male and female parameters for “single without children” is statistically significant at the 15% threshold. The higher male parameter (1.44 as against 0.68) denotes greater male benefit from being married instead of single.

(21) *I.e.*, “sex, age, socio-economic position, health, major events in childhood, major events in the previous year”.



TABLE 3. – *Probability of being at high risk for suicide, depressive or alcohol-dependent*
Logistic models 1 (simultaneously fitted for men and women)

| | | High risk for suicide | | Depression | | Alcohol dependence | |
|---------------------------------------|--|-----------------------|-----------|---------------------|----------|---------------------|-----------|
| Constant | | -6.09 *** | | -3.95 *** | | -2.32 *** | |
| Sex | Man | Ref | | Ref | | Ref | |
| | Woman | 0.57 | | 0.88 *** | | -1.56 *** | |
| Age | Man | | | | | | |
| | Woman | | | | | | |
| Age | 18-24 | -1.10 ** | -1.18 *** | -0.69 ** | -0.09 | -0.19 | -0.26 |
| | 25-34 | -0.45 | -0.18 | -0.17 | -0.11 | -0.29 ** | -0.39 ** |
| | 35-44 | Ref | Ref | Ref | Ref | Ref | Ref |
| | 45-54 | -0.25 | 0.26 | -0.02 | 0.12 | 0.00 | 0.51 *** |
| | 55-64 | -0.83 ** | -0.64 *** | -0.25 | 0.02 | -0.01 | 0.01 |
| | 65-74 | -1.57 ** | -1.45 *** | -0.77 *** | -0.01 | -0.42 ** | -0.13 |
| Household type | Single, living alone, childless | 1.44 *** | 0.68 *** | 1.09 *** | 0.71 *** | 0.06 | 0.44 ** |
| | Divorced/separated, living alone, childless | 1.99 *** | 1.54 *** | 1.19 *** | 0.87 *** | 0.27 | 0.44 * |
| | Widower, living alone, childless | 1.50 * | 0.97 *** | 1.88 *** | 0.70 *** | 0.54 * | -0.30 |
| | Single-parent family | 1.75 *** | 0.72 *** | 1.12 *** | 0.66 *** | -0.01 | 0.23 |
| | Living with partner, childless | 1.17 ** | 1.04 *** | 0.07 | 0.07 | 0.12 | 0.59 *** |
| | Living with partner and child | 0.26 | -0.10 | -0.02 | 0.42 *** | 0.18 | 0.47 ** |
| | Married, childless | -0.37 | 0.13 | 0.05 | -0.11 | -0.09 | -0.05 |
| | Married, children | Ref | Ref | Ref | Ref | Ref | Ref |
| | Other situations ¹ | 1.76 *** | 0.84 ** | 0.55 * | -0.18 | -0.07 | -0.24 |
| Educational attainment | None or not stated | -0.34 | 0.30 | 0.29 | 0.33 *** | -0.06 | -0.94 *** |
| | Elementary or secondary school only | -0.05 | 0.43 * | 0.27 | 0.32 *** | -0.08 | -0.33 * |
| | Vocational certificate | -0.05 | 0.30 | 0.11 | 0.23 ** | 0.07 | -0.34 * |
| | Baccalauréat [High school degree] | Ref | Ref | Ref | Ref | Ref | Ref |
| | Higher education | -0.87 * | 0.17 | -0.20 | -0.22 * | 0.09 | 0.33 ** |
| Household income per consumption unit | 1 st quintile | -0.14 | 0.02 | 0.22 | 0.25 ** | -0.04 | 0.17 |
| | 2 nd quintile | 0.23 | -0.01 | -0.02 | -0.03 | -0.06 | -0.11 |
| | 3 rd quintile | Ref | Ref | Ref | Ref | Ref | Ref |
| | 4 th quintile | -0.02 | 0.22 | 0.15 | -0.17 | 0.03 | 0.25 |
| | 5 th quintile | 0.25 | -0.32 | -0.21 | 0.00 | 0.19 * | 0.47 *** |
| | Activity status | Working | Ref | Ref | Ref | Ref | Ref |
| Unemployed | 0.44 | 0.00 | 0.36 ** | 0.50 *** | 0.43 ** | -0.11 | |
| Unoccupied | 0.09 | 0.37 ** | 0.38 ** | 0.24 *** | 0.06 | 0.06 | |
| Disability | 1.69 *** | 0.81 *** | 1.32 *** | 1.11 *** | 0.35 *** | -0.18 | |
| Major childhood events | Father or mother: death, disease, handicap or serious accident | 0.45 * | 0.64 *** | 0.10 | 0.20 ** | 0.21 ** | 0.21 |
| | Parents: separation or serious quarreling | 1.18 *** | 0.83 *** | 0.47 *** | 0.27 *** | 0.34 *** | 0.49 *** |
| | Difficult material situation ² | 0.27 | 0.41 *** | 0.66 *** | 0.46 *** | 0.26 ** | 0.12 |
| | Major events in the previous year | / | / | 0.15 | 0.30 *** | 0.22 *** | 0.22 * |
| | Death of someone close | 2.02 *** | 1.33 *** | 1.25 *** | 1.02 *** | 0.44 *** | 0.58 *** |
| Major events in the previous year | Particular material difficulty ³ | 1.55 *** | 1.13 *** | 0.93 *** | 0.52 *** | 0.15 | 0.67 *** |
| | Occupational or educational difficulty ⁴ | | | | | | |
| Percent concordant | | 82 | | 78 | | 71 | |
| Number of observations | | 379 out of 25,857 | | 1,714 out of 17,815 | | 1,350 out of 17,815 | |

Source: INPES Baromètre Santé 2005 for suicide risk and INSEE's Enquête Santé 2002-2003 for depression and alcohol dependence. Our modeling.

Frame: Heads of household and their partners.

*** significant at 1%, ** significant at 5%, *** significant at 10%.

Difference between men/women coefficients significant at  5%
 15%

¹ Households including persons (either relatives or not) other than partner and possible children.

² Money problems during childhood, for high risk for suicide.

³ Quarreling with friends or money problems, for high risk for suicide.

⁴ Difficulties, poor scholastic results, for high risk for suicide.

But mightn't the protection enjoyed by people in couples be due to the simple fact of not being alone? To what active factor is this protection due? Is it the presence of another person living in the same place – a person who could just as well be a parent, relative, friend or child as a spouse or intimate partner – that keeps away “grim thoughts”, or is it the tie between the individuals in question? More theoretically, do the integrative virtues of the people one lives with concern the quantity or the “quality” of interactions? We observe that the benefit in question is primarily due to being part of a couple. Sharing a residence with persons other than intimate partner and/or possible children (*e.g.*, parents or relatives, friends, roommates) actually increases the probability of being at risk for suicide for both sexes and men's chances of experiencing depressive episodes. The observed gain therefore is not due to the simple fact of not living alone; it is due to living with the “significant other” or intimate partner (Gove, Hughes and Briggs Style, 1983). And children's presence has no effect, either negative or positive, on married individuals' ill-being. The “marriage” benefit is therefore due not to children's presence but to intimate partner's. These results are illuminating in more ways than one. They suggest that the protection we get from our intimate partners is not of the same order as the closeness we have to friends, parents and children, nor does it derive from our social representation of the tie (the norm requires us to love our children and parents) nor even, it would seem, to the strength of that affective tie (can one be said to love one's intimate partner *more* than one's children?). What original quality does the intimate partner have that other relations do not, or at least not as strongly? We can only hypothesize: above and beyond any romantic vision of the love tie, it may be that this quality lies in intimate partner's ability to provide a stable environment for his or her intimate partner, to “reassure” him or her in coping with the vicissitudes of daily life – *i.e.*, the intimate partner's support-giving role.

While both sexes benefit from union, men benefit more than women. Single men living alone or heading single-parent families are at a higher risk for suicide and depression than women in the same situation (Table 3). Likewise, widowers living alone are much more likely to experience ill-being in all its forms than widows. These results are consistent with the observation that men benefit more from conjugal life than women. There is one exception, however: single women living alone are more likely to be alcohol dependent, indicating a possible benefit of union for women. The particularity of this indicator in terms of social distribution should be noted: whereas socio-economic position has little influence on men's excessive alcohol consumption, female alcohol dependence is mainly found among highly educated women with comfortable incomes, probably women less subjected to social control, who therefore do not conform closely to behavior that is socially consistent with their gender. Regular or daily alcohol consumption by women also goes together with an inversion of the social ladder: here the respective behaviors of male and female senior executives are similar and reflect a change in how alcohol is valued: increasingly synonymous with independence for women and weakness for men (Beck, Legleye and Peretti, 2006).

The benefit of marriage for women

Should we speak of a benefit of marriage *per se* or more generally of a benefit from living with an intimate partner? Comparing married people and people living together allows us to observe effects due to union type (marriage or cohabitation) and so to get a clearer idea of the situation. Married men or men living with women, either with or without children, are the least likely to experience any type of ill-being.⁽²²⁾ This confirms the beneficial effect of union for men, regardless of union type. For women, the benefit of living in a couple, though not as great as for men, is enhanced by a benefit from being married. Married women show the lowest levels of ill-being, lower also, that is, than cohabiting women. Marriage is no longer an excessive constraint for women. Contrary to Durkheim's observation a century ago, it is women who now benefit more from marriage strictly speaking, *i.e.*, marriage as a particular form of union.

While the institutionalization of divorce works in favor of married women as Durkheim predicted, divorce itself has created new risks for the family (Singly, [1987] 2003). Up against the eventuality of separation, marriage has become a legal protection for women. The family is one of the places where inequalities between men and women are most perceptible. Having children generally means that women withdraw either entirely or in part from the labor market, and it reduces their autonomy and relationships, thereby also making them more socially vulnerable in case of separation. This is why the cost of marriage for women –the fact that marriage limits their career prospects– seems particularly high in case of divorce. Divorced women, particularly women with no children to support, are at the highest risk for suicide, depression and alcoholism and they suffer the most from a broken marriage tie. The disadvantage that single men and divorced women are at surely pertains to the distinct benefits each sex finds in marriage. While marriage provides social support and increases material well-being, the family integration factor is stronger for men, whereas women are more sensitive to the economic factor. When marriages come apart, women suffer from a reduced living standard, men from solitude (Gerstel, Riessman and Rosenfield, 1985; Umberson, Wortman and Kessler, 1992).

Despite the fact that cohabitation is a less traditional form of union than marriage, it seems to be less favorable to women. The possibility of a selection effect for cohabitants *versus* spouses cannot be entirely excluded. Religion, which condemns suicide, may also determine whether individuals choose marriage or cohabitation. However, religion clearly has no significant impact on high risk for suicide.⁽²³⁾ Similarly, studies of a cohort of young

(22) Except for suicide risk, which is greater among male cohabitators without children.

(23) This was checked by running a logistic model not shown here on Baromètre Santé data. With other characteristics controlled for,

religious practice and sense of belonging to a religion do not have a significant impact on high risk for suicide. We could not test the effect of religion on our other indicators, because the Enquête Santé does not provide this information.

adults who began as single shows that living together is associated with excessive alcohol consumption but not depression (Horwitz and White, 1998). Consequently, the negative effects of living together are not due only to selection of individuals more likely to experience ill-being. The situation of women cohabitants may be explained by the fact that they take on the tasks of running family life and undergo the work-related consequences of this without enjoying the relative security (particularly material security) that comes with marriage in cases of separation from or death of their intimate partner. In fact, the greater likelihood of cohabitants being depressive (compared to married persons) is due primarily to the feeling that the relationship is not a stable one (Brown, 2000).

The effect of children is to block the path to suicide

French suicide data cannot be used to check Durkheim and Halbwachs' claim about the protection provided by children,⁽²⁴⁾ but we can observe the effect of their presence in the household on less radical expressions of ill-being. For married men and women, the presence or absence of children has no impact on high risk for suicide, depression or alcohol dependence (Table 3). This result confirms that union has a beneficial effect regardless of whether children are present (Brown, 2000). Nor does number of children living at home have any influence. With other characteristics controlled for, whether men or women have one or several children living with them does not have a significant effect on their suicidal, depressive or alcoholic tendencies (Table 4). There is thus nothing proved about the role of children in protecting against ill-being. Ross, Mirowsky and Goldsteen's 1990 review of the literature already showed that the effect of children in the household was generally nil. Since then, it has actually been shown that the presence of minors aggravates mothers' depressive tendencies (Umberson, Chen, House *et al.*, 1996). Researchers generally put forward two reasons to explain the fact that the presence of children may reduce parents' psychological well-being. First, it increases economic and domestic constraints on families; second, because of how important they are in emotional relations, children may diminish the support that partners provide for each other (Ross, Mirowsky and Goldsteen, 1990).

(24) However, a Danish study shows that the presence of young children reduces the probability of suicide, particularly among women (Qin, Mortensen, Agerbo *et al.*, 2000).

TABLE 4. – *Probability of being at high risk for suicide, depressed or alcohol-dependent*
Logistic models 2
(simultaneously fitted for men and women and including number of dependent children)

| | High risk for suicide | | Depression | | Alcohol dependence | |
|-----------------------------------|-----------------------|------------|------------|------------|--------------------|------------|
| | Man | Woman | Man | Woman | Man | Woman |
| Household type | | | | | | |
| Single, no partner | 1.98 *** | 0.47 ** | 1.03 *** | 0.76 *** | 0.12 | 0.43 ** |
| Divorced/separated, no partner | 2.51 *** | 1.48 *** | 1.02 *** | 0.80 *** | 0.32 ** | 0.27 |
| Widowed, no partner | 2.07 ** | 0.95 *** | 1.85 *** | 0.78 *** | 0.46 * | -0.27 |
| Single, cohabitating | 0.74 * | 0.22 | -0.13 | 0.32 *** | 0.16 | 0.43 ** |
| Married, cohabitating | <i>Ref</i> | <i>Ref</i> | <i>Ref</i> | <i>Ref</i> | <i>Ref</i> | <i>Ref</i> |
| Divorced or widowed, cohabitating | 1.44 *** | 1.11 *** | 0.34 | 0.31 | 0.29 | 0.82 *** |
| Other types | 1.79 *** | 0.74 * | 0.51 ** | -0.14 | -0.02 | -0.23 |
| Number of children in residence | | | | | | |
| 0 | 0.53 | 0.24 | 0.16 | -0.01 | -0.06 | 0.16 |
| 1 | 0.52 | -0.32 | 0.07 | 0.12 | -0.03 | 0.18 |
| 2 | <i>Ref</i> | <i>Ref</i> | <i>Ref</i> | <i>Ref</i> | <i>Ref</i> | <i>Ref</i> |
| 3 or more | 0.56 | -0.27 | 0.19 | 0.02 | 0.10 | 0.04 |

Source: INPES' Baromètre Santé 2005 for suicide risk and INSEE's Enquête Santé 2002-2003 for depression and alcohol dependence. Our modeling.

Frame: Individuals with children.

Models adjusted by sex, age, educational attainment, household income, activity status, health, major childhood events, major events during the previous year.

There is often a misunderstanding about the nature of interaction between family members. Neither Durkheim nor Halbwachs really defined the nature of such interaction. One spontaneously tends to think of their bright side: tenderness, emotional support, benefits gotten from the various exchanges, various forms of material and psychological support –in sum the well-being we derive from our family members and that make them dear to us. However, limiting ourselves to these interactions, regardless of how real they are, would be reductive. The nature of interactions with family members is multiple: affective, utilitarian, but also constraining, problematic. In fact, having a family means having to take it into account in one's daily acts and activities; it means taking care of household chores and children, running the house, responding to administrative demands, being there when the others are there, negotiating small and large decisions, etc. These constraints are also actions that organize the individual's daily life and structure his or her time, in the same way working hours do. Family interaction is also affected by the respective social positions, activity statuses, occupations and income contributions of family members, and women are often in a position of dependence on these points. It is the entire set of social support and constraint interactions, together with the sharing of "goals, duties, *raisons d'être*" (Marcel, 2000, p. 154), that produces family integration. It is therefore important to dissociate well-being and integration: integration is not enough *in and of itself* to produce well-being. Serge Paugam points out that poverty does not necessarily involve social exclusion –quite the contrary. He identifies a type of

“integrative poverty”, operative primarily in southern Europe and deriving from the fact that “collective resistance against poverty may involve intense exchanges within and among families, as well as many forms of solidarity due to physical proximity, and this may mean that poor people are considered perfectly integrated into the social fabric” (Paugam, 2005, p. 79). This in turn means that within the concept of family integration (particularly relative to children) it is important to distinguish between relations of constraint, which can, in acute situations, engender ill-being, and supportive relations, which generate well-being (Umberson, Chen, House *et al.*, 1996).

In our study, only single-mother heads of household benefit from the shared life with their children: their statistical probability of being at high risk for suicide is lower than for divorced persons without dependent children. This could be explained by the change in the nature of parent-child relationships after separation, the hypothesis being that the emotional void caused by the absence of mother’s partner is in part compensated by a closer tie between mother and child; that is, children function as a partial emotional substitute for the missing partner. For men, on the other hand, living only with their children generates higher risk for suicide and depression –the levels are similar to those for men living alone– showing that for them the presence of children does not fill the void created by the absence of the female partner. Contrary to fathers, women are not penalized by the additional domestic and parental work of raising their child(ren) alone because they were already handling most of that burden when living with a partner or spouse.

While cohabitants suffer from the insecurity inherent in that relationship, the presence of children seems to consolidate the couple, making separation even more difficult. However, like Brown (2000), we note that the presence of children aggravates cohabiting women’s depressive tendencies (Table 3). Another difference between married women and cohabitating ones (in addition to the marriage contract and the security it offers against the eventuality of separation) should be pointed out. Men and women living together without being married are more critical of traditional male and female roles and more egalitarian in distribution of domestic chores –but only before any children are born. The negative effect of children on depression for cohabiting women can thus be explained by the fact that when children are born, traditional roles tend to take precedence in couples who had otherwise broken with tradition: “In identity terms, this amounts to claiming that the difference between a ‘cohabiting woman’ and a ‘married woman’ fades when the ‘mother’ dimension takes over.” (Singly, 1987, p. 219). If we adopt Besnard’s redefinition of “regulation” as the social expectations associated with male and female roles in the couple, children can be considered a source of excessive regulation for women because their presence has the effect of maintaining traditional roles. This constraint would then be particularly oppressive for women who were indeed aspiring to get clear of social representations of their sex. The fact that this negative effect is not observed for married women would then be explained by the fact that, through selection, married women are more inclined to adopt traditional role distribution.

For women, cohabiting increases the risk of being alcohol-dependent with or without children, the likelihood of being at high risk for suicide without children, and experience of depressive episodes with children (Table 3). The presence of children thus does not protect cohabiting women from ill-being overall; instead, it determines what kind of ill-being they will suffer from. While regulation through marriage has changed because the institution itself has evolved, as has the place of women and the couple in society, this argument is not as relevant for children, because even though parent/child relations have also evolved, none of this explains the “weakening” of children’s integrative effect. Reflecting on Durkheim’s results, Halbwachs ([1930] 2002, 1978) empirically brought to light that protection against suicide increases with the presence of children and as the family grows. We need to reformulate the question in light of the other ways of expressing ill-being. Though the presence of children reduces suicidal tendencies, children do not protect against other forms of ill-being. It follows from this that their effect is not on ill-being in general but only on the act of suicide, completed or contemplated. This apparent tautology authorizes us to claim that in connection with children, the specificity of suicide is abandoning children to the possible partner. It is therefore not surprising that the presence of children weighs heavily on women no longer living with a partner: if they committed suicide, they would leave their children to an uncertain future.

These results lead us to call into question the hypothesis that the increase in family integration due to children protects people from suicide. Children are less a protection against suicide than a constraint on each parent. While doing the deed can in no way be equated with a cold calculation of advantages and disadvantages, still, the abandonment induced by the suicide’s death necessarily plays some role, either consciously or unconsciously, in the unhappy individual’s decision. Society firmly condemns the act of abandoning one’s children; to do so is to break a taboo. The effect of this may be to preclude even the possibility of contemplating suicide. The strong socially constructed dependency ties linking mother and child (stronger, that is, than those linking father and child), the incorporation of the maternal value of protecting one’s offspring, the mother’s “specific” responsibility toward her child(ren) make suicide even more difficult for mothers. It is therefore the abandoning of children that indirectly keeps fathers and, still more effectively, mothers from committing suicide, rather than any family integration due to those children. Children are not so much protection from ill-being as a constraint that blocks the path to suicide.

*
* *

The differential between men’s and women’s suicide rates is not due to any female immunity to suicide, whatever the reason given to explain that immunity. Given differentiated socialization during childhood and the different places and roles assigned or attributed to the two sexes, women’s immunity to suicide is more likely to derive from the fact that each gender has its own way

of responding to the various tensions that life induces in people. If there had been suitable data, we might have added such diverse ways of expressing ill-being as drug abuse, violent behavior, suicide attempts, bulimia, anorexia, etc., which are all also indicators of tensions between a gendered individual and society. The social construction of gender shows the degree to which the incorporation of inculcated values determines even our most private, personal reactions, reactions on which we have little direct grip. Men and women alike are dependent on the social positions they are assigned, and the type of response to tension depends on the particular values integrated by each sex. Studying suicide alone as an indicator of individuals' ill-being or of the "social happiness" or "health" of a given social system (Durkheim [1897] 1997, pp. 225-226, 1951) thus leads to a partial vision and is likely to lead to erroneous conclusions, particularly in comparing men and women. We have to give up the idea that a single way of expressing ill-being is the only relevant way. In the case of suicide, this implicitly leads to the odd conclusion that women get marginal benefit from being socially dominated.

One of the mistaken ideas induced by considering suicide alone is that greater protection against ill-being is due to stronger family integration, due in turn to the presence of children. Durkheim explained the benefits of integration in terms of family density and the collective feelings shared by family members. Our results call this analysis into question in that children prove less "protective" against ill-being than spouse or intimate partner. We did not find the relational benefits predicted by Durkheim and Halbwachs, though through the social taboo against abandoning children, the corollary of their presence is to block the path to suicide. This means that in the nuclear family, the nature or quality of family members' interaction is more important than the "density" of the family group and therefore more important than the density of interactions. Because the protective qualities of children have more to do with interactions in the form of support than interactions involving constraint, the burden of children's presence in the household, borne primarily by the mother, is likely to partially cancel out the positive aspects of parent-child relations. The relative protection enjoyed by single-mother heads of household teaches that the benefits of relationships with family members also depend on relational configurations, since the presence of a partner changes the range of relations among the actors and the respective benefits each stands to obtain. In the end, it seems to be integration by way of the couple –rather than the "family society"– that has the virtue of protecting people from ill-being, and this goes against Durkheim's hypothesis on suicide. Likewise, the *quality* of conjugal relations assumes more importance than the fact of living together. Staying married when the relationship is considered unsatisfactory is more harmful in terms of mental health than living alone permanently or being separated (Gove, Hughes and Briggs Style, 1983; Ross, 1995; Williams, 2003). In Durkheim's analysis, the beneficial effects were due to greater integration; *i.e.*, the intensity of collective life (see n. 1). Sticking to Durkheim's definition of integration, current research and our own conclusions attest to the importance of the "quality" of family relations. But "quality" should not be understood in the narrow, vague sense of

good relationships. It is not so much the “depth” of relations that seems to be at issue –the relationship one has with aged or handicapped parents that one is required to take care of may be deep– but the type of relationship; *i.e.*, one of support or constraint. On the basis of previous remarks, and to paraphrase Baudelot and Establet’s theory of the integration concept, we would modify it thus: how protected an individual is from ill-being is a function of the “quality” of the relationships he or she has with family members, particularly spouse or intimate partner, within a given family configuration.⁽²⁵⁾

Obviously before we can speak of the quality of a relationship, that relationship has to exist. People living alone are the predetermined victims of weak family integration, and our results confirm much of what Durkheim showed in 1897 about single persons. The fact that while the number of persons living alone in France has tripled since the late 1960s, this has not led to a proportionate increase in suicide rates may seem surprising.⁽²⁶⁾ Actually, the relative stability of the overall suicide rate since that time conceals changes in the way ill-being is expressed. It is likely that the degree of self-restraint has continued to develop,⁽²⁷⁾ thereby limiting violence against the self. If we considered suicide only, we would conclude –against all expectations– that ill-being is, if not falling, at least stagnating. This is firmly belied, however, by the continuous increase in numbers of depressive persons.

Lastly, even when the gendered nature of ways of expressing ill-being is controlled for, if there is a benefit to be had from marriage over cohabitation, it is now more likely to go to women than men. It is true that in the course of a century the very nature of the marriage institution has profoundly changed and that we are in fact comparing different objects. Union no longer has to be marital for it to be considered the legitimate frame for the couple and family. Likewise the instituting of divorce by mutual consent has sharply affected the content of marriage. Paradoxically, as women have become more autonomous and thus begun benefiting from the advantages associated with marriage, they have simultaneously become the primary victims of the couple’s new vulnerability in terms of increased exposure to ill-being. Women work now, but they are still often extra-income providers and household managers. Breaking up with their intimate partner has thus become a source of increased social vulnerability for them. Obviously the institution of divorce and the marked increase in number of separations is due to deeper changes, changes in spouses’ or partners’ relations with and expectations from each other. But these observations should not lead us to idealize the marital life of by-gone days. The pressure that women were submitted to in those days often led to

(25) Closer examination of Durkheim’s concept of regulation would be required if we were to adequately respond to criticism formulated by Philippe Besnard (1987b). The point is beyond the scope of this article, but it would be of great interest to examine the robustness of the concept, thereby reaching a more substantiated conclusion.

(26) Suicide rates began rising in France in

the mid-1980s, after the *Trente Glorieuses* [postwar period of widespread, accelerated economic growth in Europe, 1945 to 1974 approximately], then fell back to early 1960s levels.

(27) This claim does not run counter to the demonstrated increase in violent crime, which is a reflection of social tensions and exasperations.

neuroses; *i.e.*, diseases that gradually regressed over the twentieth century, whereas depression among women and, to a lesser degree, men was beginning to rise (Ehrenberg, 1998).

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APPENDIX

The 20 CES-D questions

During the past week

- 1) you've been upset by things that don't usually bother you;
- 2) you haven't wanted to eat; you've lost your appetite;
- 3) you've felt you couldn't shake the blues, even with the help of family and friends;
- 4) you've felt you're just as good as other people;
- 5) you've had trouble concentrating on what you're doing;
- 6) you've felt depressed;
- 7) every action has seemed to demand a major effort from you;
- 8) you've felt confident in the future;
- 9) you've thought your life is failure;
- 10) you've felt afraid;
- 11) you haven't slept well;
- 12) you've been happy;
- 13) you've talked less than usual;
- 14) you've felt lonely;
- 15) other people have acted in a hostile way toward you;
- 16) you've made the most of life;
- 17) you've had a crying fit;
- 18) you've felt sad;
- 19) you've felt that people didn't like you;
- 20) you've felt you lacked energy.

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