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Trajectories of despair: Understanding the social determinants of suicidality through differential vulnerability

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ABSTRACT

Suicide is a major public health issue. There are over 700,000 deaths globally and rising levels of suicidal ideation are reported. While epidemiological research has demonstrated associations between social factors and suicide, further attention is needed to understand the processes through which these factors combine, accumulate and shape vulnerability over time. Drawing on 28 qualitative interviews with third sector suicide prevention practitioners in the East of England, this study deploys the concept of differential vulnerability to examine how deprivation, isolation, trauma, substance use and other factors interact over time within what we term 'trajectories of despair.' The study suggests that suicidality is rarely attributable to single events – but instead emerges through the complex interplay of interwoven disadvantage and adversity that can reshape the social, material and relational contexts and resources available to individuals. In this way, the research contributes to understanding suicidality as socially shaped, cumulative and unevenly distributed.

1. Introduction

Suicide is a significant problem with more than 700,000 people dying annually by suicide internationally (Zhu et al., 2022). In 2024, there were 6190 suicides registered in England and Wales (which represents 11.3 suicides registered per 100,000 people) (Office for National Statistics, 2025). It is harder to reliably know how many people live in distress. However, data from the Adult Psychiatric Morbidity Survey indicate that the proportion of adults aged 16–74 reporting suicidal thoughts increased from 3.8% in 2000 to 6.7% nationally in the most recent survey, highlighting the growing scale of suicidal ideation (Butt et al., 2025).

Though it has been long established that there is a relationship between social forces and the seemingly highly individualistic act of suicide (see Durkheim, 1951), it has also been the case that suicide and its prevention have been historically pathologised/medicalised – or, in other words, (particularly in policy responses) addressed through frameworks that have prioritised mental illness and clinical intervention (Pirkis, Bantjes, et al., 2024). To effectively address suicide, however, it is necessary to centre the multiple and varied factors associated with suicidality within public health strategy and to establish long-term research and policy commitments that recognise that "although some risk factors might manifest at an individual level, the underlying causes of these risk factors are social determinants" (Pirkis, Dandona, et al., 2024: e816). Important theoretical models – including the integrated motivational-volitional model (O'Connor & Kirtley, 2018) and the narrative-crisis model (Cohen et al., 2022) – suggest that suicidal thoughts and behaviours emerge through complex, multidimensional interactions between psychological processes, life experiences, social, cultural and contextual factors. Within a multidimensional understanding of suicidality, the social determinants of suicidality represent an important area of continued research focus by highlighting how structural and material conditions shape vulnerability to suicidality (Gallagher et al., 2025; Na et al., 2025).

The social determinants of health are the conditions in which people live, work and age, and the associated structures that help manage illness, all shaped by social, political and economic factors (Commission on Social Determinants of Health, 2008). In the UK, some progress is being made in attending to the social determinants of suicidality at a national policy level. Indeed, the Suicide Prevention Strategy for England: 2023-2028 (Department of Health and Social Care, 2023) has a stronger and more explicit emphasis on the importance of the social determinants of suicide when compared with the strategy it replaced (Department of Health, 2012).

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Recent reviews of epidemiological and public health literature demonstrate the salience of the social determinants of suicidality as well as the breadth of social factors associated with suicidal thoughts, behaviours and outcomes (Gallagher et al., 2025; Na et al., 2025). These reviews show that factors including socioeconomic status, social security, education, unemployment, housing insecurity, social inclusion, discrimination, exposure to violence and abuse and a range of other forms of disadvantage and adversity are associated with suicidality. Although this evidence base demonstrates the importance of the social determinants of suicidality, the complexity of suicidality requires greater research attention on the ways in which these factors may interact or accumulate in people's lives. In this regard, quantitative intersectional analyses have demonstrated the importance of overlapping social positions and experiences of disadvantage in shaping patterns of vulnerability to suicidality (Forrest et al., 2023). However, alongside such epidemiological approaches, there is also value to be found in other forms of research that focus the analytic gaze on the processes through which the social determinants of suicidality are experienced and become consequential within people's lives over time.

Developing a deeper understanding of these processes necessitates engagement with qualitative, narrative and lived experience forms of evidence. Though epidemiological studies provide crucial evidence regarding patterns of distribution, prevalence and risk factors associated with suicidality, scholars have argued for the importance of approaches that also analyse how suicidality is experienced and understood (Chandler et al., 2022), while also seeking to locate these analyses within the wider social, cultural and material conditions that shape inequalities in suicidality (Chandler & Wright, 2024). However, qualitative research should not be understood as generating straightforward access to the causes of suicidality. Qualitative methods produce situated forms of knowledge with accounts shaped by interpretation, context and relationships built during the research process (Bantjes & Swartz, 2019). Nevertheless, qualitative work can provide important insights that help us explore and unpick how different experiences of disadvantage and adversity are understood, interpreted and become consequential in people's lives over time.

More widely, a growing body of qualitative studies has generated a range of valuable insights about the social contexts of suicidality. This includes work examining social support and loneliness (McClelland et al., 2022), community disadvantage (Polling et al., 2021), suicidality within specific institutional contexts (Walker et al., 2022) and sensemaking about suicidal experiences (Marzetti et al., 2023) among other issues. In one further significant recent example of qualitative work contributing directly to the social determinants of health literature, Price et al. (2024) conducted qualitative research in a socially deprived town in North East England with above-average rates of mortality categorised as 'deaths of despair' (see also Camacho et al., 2024; Case & Deaton, 2020). This conceptualisation captures a broader phenomenon which includes drug and alcohol-specific mortality as well as suicide. Price et al. (2024) interviewed stakeholders working with people vulnerable to drug overdoses, suicide and alcohol-specific (DSA) mortality who identified the relevant social determinants of deaths of despair in that region (including deindustrialisation, austerity policies, high unemployment, poor housing stock, normalisation of drug use and other issues). Saliently, this study revealed that experiences of despair and hopelessness were perceived as socially situated responses to deprivation, regional inequalities and experiences of adversity – rather than as being reducible to individual-level explanations alone.

Taken together, this body of qualitative work shows that experiences associated with suicidality are complex, socially situated and influenced by interwoven forms of disadvantage and adversity. However, there is an opportunity for further research to build on these insights by using conceptually informed qualitative approaches that examine the processes through which intertwined social determinants are experienced, interpreted and become consequential over time. In this paper, we use differential vulnerability (Diderichsen et al., 2001, 2012, 2019) as an analytic tool to trace the temporal compounding of social factors influencing suicidality. We examine how experiences of disadvantage and adversity can become consequential over time in different ways depending on social circumstances and access to resources.

1.1. *Differential vulnerability: A conceptual lens*

How can we build on existing evidence relating to the complex and multifactorial nature of suicidality to analyse whether and how different social determinants interact and become consequential temporally? We argue that one way of doing so is to deploy the concept of differential vulnerability developed in the work of Diderichsen and colleagues (2001; 2012; 2019). This analytic tool can help illuminate – via qualitative evidence – not only the factors that are present in people's lives but also if and how these factors interact and become of consequence in the context of suicidality. We understand vulnerability to be a social phenomenon that is contextual, relational, sensitive to power dynamics and changeable, rather than as a permanent state, trait or position that is somehow inherent to a specific group (see Brown, 2021). The concept of differential vulnerability suggests that exposure to harm – and its impacts – varies according to social position, access to resources and the cumulative impact of disadvantage and adversity. The concept directs analysts to focus on the interplay of factors that mean that some experiences continue to produce harmful consequences for certain people more than they do for others. Differential vulnerability has also been examined within mental health research where work has analysed how inequalities in psychological distress may emerge not only because of greater exposure to adversity and stressful life events, but also because the consequences of these experiences can vary across social groups and contexts (Anderson et al., 2022; Kessler, 1979).

Differential vulnerability forms part of a broader analytical framework which sets out that individuals hold unequal social positions. Furthermore, it distinguishes between exposure to harmful social conditions, vulnerability to their effects and the differential consequences that follow. Rather than assuming adverse social conditions exert uniform effects, this framework directs attention to how the same exposures can produce markedly different outcomes depending on social position, access to resources, and the cumulative impact of disadvantage and adversity over time. In this regard, we argue that in the context of narrative-based research on suicidality, differential vulnerability – and the wider framework in which it sits – provides analysts with a conceptual tool to examine if and how multiple and interconnected social forces are present in people's lives and contribute to trajectories leading towards suicidal ideation and/or suicidal behaviour.

The concept of differential vulnerability (and the wider framework in which it sits) shares important similarities with other concepts relevant to the analysis of the social determinants of health. For example, cumulative advantage/disadvantage theory suggests that social advantages and disadvantages can accumulate and widen over time, with earlier experiences shaping outcomes, resources and opportunities later (Dannefer, 2003). Syndemic theory meanwhile demonstrates the value of moving beyond a focus on individual risk factors to instead examine the clustering and interaction of multiple health and social problems under conditions of inequality (Singer et al., 2017). Similarly, fundamental causes theory highlights how social conditions – because of their impact on access to resources and opportunities – can shape multiple health outcomes via multiple mechanisms, whilst also maintaining health inequalities even when specific mechanisms change (Link & Phelan, 1995). Overall, these important concepts offer insights into the development of inequalities temporally, the clustering/interaction of multiple forms of disadvantage and provide a lens through which to understand how structural conditions maintain unequal health outcomes. However, we argue that the framework offered by Diderichsen and colleagues – and particularly the concept of differential vulnerability – offers a distinct analytic focus and direction. In the context of suicidality, it provides a lens more attuned to examining why

combinations of exposures to disadvantage and adversity may become consequential in different ways depending on social position, circumstances and access to resources.

2. Methods

2.1. Background considerations

Similarly to Price et al. (2024), we approached the task of developing a narrative understanding of the social determinants of suicide and suicidal ideation by generating data with suicide prevention professionals, volunteers, and practitioners in adjacent services. A strength was that this strategy enabled us to gather evidence pertaining to multiple lives and the varied experiences of a range of people supported in the work of the practitioners – rather than being restricted to single experiences. Additionally, it enabled us to gain insight into third sector perspectives on the strengths and weaknesses of current suicide prevention activity locally (this analysis is reported elsewhere).

It is important to note that the research team carefully considered conducting data collection directly with people with lived experience of suicidality. Had we done so, we recognise that for some potential participants it is possible that they may have found value in the opportunity to use their experiences of suicidality to contribute to research or potentially impact suicide prevention. However, the research team lacked specialist training in supporting people affected by suicidality. Reflecting on our ethical responsibilities, we decided instead to focus the research on practitioner narratives about the people they support in their work, rather than on people with lived experiences of suicidality directly.

Though providing valuable insights into the patterns and processes associated with suicidality over time, it is important to note that our analysis of narrative accounts of the lives of people affected by suicidality are mediated through practitioner interpretation. In this regard, we recognise that the decision to focus on practitioner narratives rather than lived experience was a consequential epistemological choice. Practitioner accounts represent a certain type of situated knowledge that has been shaped by their professional or voluntary role, training and/or disciplinary background, the specific organisational context in which they work, and the experiences accumulated across both their professional and personal lives pertaining to suicidality and associated issues. As a result, our analysis reveals practitioner interpretations of the interaction and accumulation of the social determinants of suicidality over time – rather than claiming to represent lived experiences of suicidality.

2.2. Recruitment, data collection and analysis

We utilised semi-structured interviews organised around an indicative topic guide with several pre-defined topic areas. This was informed by existing literature on the social determinants of suicidality and the research team's knowledge of the wider evidence base concerning social, material and relational influences on suicidality. We deployed a combination of purposive and snowball sampling to identify relevant practitioners and volunteers, drawing on their networks within suicide prevention and the third sector to recommend additional interviewees and organisations. 28 interviews were conducted overall. In line with participant preference, 25 interviews were conducted online via Microsoft Teams and three were conducted in person at the offices of participant organisations.

All interviewees were drawn from third sector organisations in the East of England providing a range of crisis-alternative and peer and community support, and some were also engaged in advocacy work. Participants held a variety of frontline, community and strategic leadership roles across 14 charitable organisations in the East of England focusing on suicide, mental health, drugs and alcohol, gambling and asylum and immigration.

Interviewing practitioners from the third sector ultimately enabled us to generate a range of rich insights about the social forces that shape suicidality across parts of the East of England and how these social forces might intersect. This helped explore the interwoven everyday struggles of the people the practitioners supported in their work with money, social isolation, substance abuse and other issues that can generate vulnerability to suicidality.

Data were analysed using the seven-stage framework analysis procedure (as outlined by Gale et al., 2013). After transcription and familiarisation, the research team developed an initial coding framework. This was primarily rooted in a deductive approach informed by our interests in vulnerability and the existing literature on the social determinants of suicidality. The framework was tested against a small number of initial transcripts. It was then refined through discussion within the research team to maximise consistency, clarity and analytic relevance. All 28 transcripts were then coded using the agreed coding framework. Additional codes were created where issues not captured by the coding framework were identified within the data. Our approach allowed for extracts to be assigned to multiple codes. Instances of cross coding were not treated as inconsistencies or problems but rather as reflecting the interconnected nature of vulnerability to suicidality as described by our participants. Following the completion of coding, the research team engaged in thematic refinement by assessing coherence both within and between themes. Final themes were developed collaboratively through discussion of the strongest patterns within the dataset. Overall, the analysis produced a broad set of themes across the dataset. In this paper we report eight themes that most clearly address the social determinants of suicidality and the interconnected nature of vulnerability.

3. Findings

In this section, we present findings from our framework analysis of practitioner accounts. With the conceptual lens of differential vulnerability used to structure the analysis, we focus on how exposure to specific social forces – and the interconnections between these experiences – can be understood to both configure and reshape vulnerability to suicidality. Though our participants often spoke about specific domains of social determinants – including deprivation, social isolation, substance use, abuse, trauma and beyond – these factors were discussed alongside and in connection with a range of other social factors. In other words, participants often discussed how suicidality was shaped by interconnected experiences of disadvantage and adversity. In this regard, even where we discuss specific domains, our analysis recognises that these domains interact with other social forces and are embedded within a wider, overlapping social, material and relational context.

We order our findings in two parts – with each part containing a range of themes (see Table 1). Part one presents analysis of the domains of social determinants of suicidality that were most strongly and consistently discussed by participants, across five identified themes.[1] These domains are framed as significant exposures that may contribute to increased vulnerability. Though certain social factors were given greater weight by some respondents, all participants also regularly acknowledged interconnection. With these domains established, part two of the analysis focuses more explicitly on the cumulative and interwoven nature of vulnerability to suicidality. Here we examine how participants described the cumulative importance of multiple factors, showing how vulnerability varied depending on configurations of

[1] We recognise that social determinants of health encompass a wide range of social, contextual and material factors. In this paper, we use the term to reflect not only macro-level structural conditions and socioeconomic factors but also socially patterned experiences of adversity and harm – including abuse, trauma, substance use and gambling – which are shaped by and interact with other social and material conditions (consistent with Pirkis, Bantjes, et al., 2024).

Table 1
List of themes.

Part 1: Specific Social Determinants of Suicidality	**Brief Description**
1.1 Structural and Material Insecurity	Material and structural insecurity (e.g. financial precarity and lack of housing, employment and welfare security) undermined stability and positive sense of the future.
1.2 Social Isolation and Disconnection	Weakened social ties and breakdown of relationships reduced emotional support and eroded sense of belonging.
1.3 Abuse and Trauma	Experiences of abuse and trauma were described as having long-term impacts – creating instability, distrust and hopelessness.
1.4 Substance Use and Gambling	Substance use and gambling functioned as coping responses to disadvantage and adversity but may also have compounded harm and increased impulsivity.
1.5 Masculinity and Gendered Expectations	Gendered expectations, especially around the norms of masculinity, connected economic strain to despair and constrained help-seeking behaviour.
Part 2: Cumulative and Interconnected Nature of Suicidality	**Brief Description**
2.1 Layers of Adversity and the Accrual of Despair	Suicidality generated by the cumulative interaction of multiple forms of disadvantage and adversity over time.
2.2 Trajectories of Despair	Despair unfolds along varied pathways reflecting the interplay of different forms of disadvantage and adversity, leading to divergent outcomes.
2.3 Points of Crisis	Without being causal, specific events or experiences represent the moment where people feel unable to cope or escape.

disadvantage and adversity, and how despair was understood as unfolding and developing over time as multiple factors coalesced and combined. Part two is comprised of three themes.

4. Part one: Specific social determinants

4.1. Theme 1.1: Structural and material insecurity

In this theme, we present data extracts relating to how exposure to deprivation and financial precarity, housing insecurity, unemployment and job precarity, and lack of welfare support were described as structural drivers of vulnerability to suicidality in that they undermine stability, security, erode resources to respond to adversity, and diminish a positive sense of future possibilities. While these factors represent distinct forms of disadvantage and adversity, they are considered together in this theme because participants commonly described them as linked dimensions of material insecurity. Rather than operating discretely, participants understood these factors as mutually reinforcing and interconnected. In this way, difficulties in one area (e.g. job loss) were often described as leading to challenges in other areas (e.g. housing).

Participants consistently discussed the significance of deprivation and financial precarity in the lives of the people they supported in their work. As the following extracts demonstrate, limited financial resources were noted by participants to be an important part of the picture of vulnerability to suicidality:

> Extract 1.1.1: It's not always down to like they're struggling financially, but a majority of the people that have come through our doors are struggling financially. (SPPV27)
> Extract 1.1.2: The fact that they're, um, possibly reliant on benefits. Um, they haven't got money to go around. The children want the latest whatever. Um, they might borrow money to provide that for their children, thinking that that's going to make them happy. Um, so in that respect, yeah, there's a lot of, there's a lot of deprivation with, um, money factors. (SPPV24)

The significance of relative deprivation and hidden poverty is also revealed in the extract 1.1.3:

> Extract 1.1.3: And it is an area of, of big affluence, but it's also got pockets of high deprivation. And I think that stigma's really exacerbated because there's lots of range rovers driving around. There's lots of big houses, but that's not everyone's reality. (SPPV12)

This participant suggested that experiences of material insecurity could become intertwined with stigma associated with having limited resources in an otherwise affluent area. This suggests an important comparative component in vulnerability to suicidality, whereby perceived negative status differences to the resources and lifestyles of others contribute to feelings of suicidality. Another participant (extract 1.1.4) noted the significance of growing pressures around the cost of living:

> Extract 1.1.4: … um, the struggles of, um, you think everything's all right, and then, you know, example, cost of living crisis. Yeah. You know, it, it, it does affect people because what happens is, the first thing to, what we hear a lot is the first thing to slip when you're struggling financially, for example, is you don't do the stuff that makes you happy. It's about putting food on the table. It's about keeping the rent paid. It's about keeping the bills paid. (SPPV19)

Here SPPV19, explicitly connected financial pressures with declining wellbeing. This demonstrates the interaction between declining material circumstances and how these undermine any wider sense of an alternative, more positive situation. The looming threat of homelessness also created distress – and in this sense, hopelessness was seen as a reaction to adverse social conditions. As is evident in extract 1.1.5, housing issues were connected in other ways to suicidality by our participants:

> Extract 1.1.5: We know that there isn't really enough in the way of social housing, so that's a big factor. And I think a lot of the time with that is because people don't have a choice really in what they're being given. They're given like one choice, and it's a very narrow path, and that [is] a big factor because having that control over a situation yourself is a factor, I think, into suicidal thoughts as well, losing that control over having choices. (SPPV7)

In this extract, our participant suggested that lack of choice around housing for those seeking to access affordable social housing can shape vulnerability because it narrows their sense of their own agency and horizons of possibility.

In the following data (extract 1.1.6), the participant similarly described how job loss/unemployment can lead to feelings of despair:

> Extract 1.1.6: But we, we've also seen people that have lost jobs and then haven't been able to keep up with the mortgage payments and have reached out to us for support with things like that. Um, because they get into a point where they, they don't know what else to do. And for some reason suicide becomes more than a fleeting thought. It becomes an option. (SPPV12)

Vulnerability here is heightened by the hopelessness that respondents reported people felt in relation to the financial pressures that emerged after exposure to job loss or a period of unemployment.

Overall, the extracts presented in this theme suggest that as pressure associated with exposure to material insecurity accumulated within people's lives, vulnerability to suicidality was thought to increase.

Importantly, material insecurity was rarely described as operating in isolation. Instead, participants suggested that material financial precarity, housing insecurity, employment difficulties and similar issues could contribute to an unstable foundation where other experiences of disadvantage and adversity became more difficult to manage or cope with. We now turn to consider the second identified theme.

4.2. Theme 1.2: Social isolation and disconnection

Participants frequently discussed the role of high levels of social isolation and disconnection as significant factors shaping vulnerability to suicidality in the lives of the people they supported. Though not divorced from issues of material insecurity discussed above, loneliness and lack of social connection were framed by participants as having their own consequences on people's sense of belonging, of life being worth living and access to sources of support. Across the extracts that follow, the participants' accounts revealed that the structure of and challenges inherent to contemporary social life were making people feel evermore isolated and lacking in a sense of belonging.

In the first extract (extract 1.2.1), we can see how participant accounts highlighted the diverse causes and extent of loneliness in their client base:

> Extract 1.2.1: So from my perspective, one of the biggest causes of why the people I work with feel suicidal, um, often comes down to loneliness. Uh, so I work with a very lot of very isolated people, and whether that's through, you know, their, their mental health declining, they've lost connections with people, um, or they don't have the social skills or confidence, um, or just the way our society is kind of set up now, like discombobulated from one another, the upcoming of the digital age and whatnot. They, they're very isolated people. (SPPV17)

This participant pointed towards the structural causes of loneliness, suggesting that experiences of isolation and disconnection are shaped by broader societal trends that create atomised forms of social life. Furthermore, in extract 1.2.2, it is suggested that the lasting impacts of the COVID-19 pandemic had intensified a sense of disconnection in the people they support:

> Extract 1.2.2: You've got guys that, you know, struggle within the community, because, um, there's a lot of people that feel that you, you know, communities have been lost, um, because certainly since the pandemic. That often comes up, you know, a lot of, a lot of guys have, um, struggled since the pandemic because we, we lost a lot of connections and we're almost isolated in our, in our households. And if, if, if we're isolated in our households, but then the household environment isn't pleasant either, what, what, where do we look? Where do we go? (SPPV19)

This participant suggested that the legacy of the pandemic has been one of corrosion of local community, leaving individuals feeling cut off from everyday interaction and sources of connection. Towards the end of the extract, this participant also highlighted how experiences of isolation could become particularly significant when combined with other forms of adversity, such as experiences of a difficult home life.

Moreover, digital technologies and social media – which have become even more prominent and significant in society since the pandemic – were described in extract 1.2.3 as having reshaped experiences of isolation and disconnection in unique ways:

> Extract 1.2.3: And I think that the other thing that we've noticed more increasingly, um, since the pandemic, so since sort of 2020, let's say, um, the increase we feel that we're seeing is the way in which we communicate, um, you know, it's the screens, you know, that people spend more time connecting on social media, you know, everything they do, it's on X, it's on Facebook, it's on Twitter, it's on Snapchat, um, it's on all of those things. And we're spending less time interacting with humans. (SPPV23)

In this quote, SPPV23 attributed social disconnection as contributing to altered patterns of social connection. Online forms of interaction were viewed as potentially replacing or limiting opportunities for face-to-face communication, contributing to changing experiences of isolation and disconnection.

Participants also described the salience of the loss, breakdown or lack of family connections and romantic relationships:

> Extract 1.2.4: Uh, the majority of clients don't have significant people in their lives, particularly I think around family. They might have the odd friend. Um, but I think family, family issues, um, are a huge impact because of the lack of support. Um, and that also, I suppose people move around a lot more than we used to, um, in terms of not living near family or, uh, yeah. But I think, yes, a lot. I think the majority of my clients on my caseload right now will be and are particularly isolated. (SPPV26)

Extract 1.2.4 demonstrates how the absence or breakdown of family relationships was described as reducing access to salient sources of emotional support when feelings of despair developed. In this regard, vulnerability to suicidality was understood as shaped not only by experiences of loneliness but also by the extent or availability of supportive relationships during periods of adversity. In the next extract, meanwhile, we can see similarly the significance of intimate partner relationship breakdown:

> Extract 1.2.5: For men is, perhaps when we talk to people about, you know, [they've] got to 45 and … not married, or [they've] lost access to [the] kids through the breakdown of relationship. That's a real biggie … So, for men, loss of relationship with children and with life partners is a huge thing. (SPPV6)

Overall, participants described experiences of isolation and disconnection not only in terms of the harms of loneliness itself, but also because relationships represented significant sources of emotional and social support that could shape how other types of disadvantage and adversity were experienced or managed. In this regard the absence or breakdown of relationships was described as reducing resources available to people when navigating other challenging experiences.

4.3. Theme 1.3: Abuse and trauma

Participants frequently described how they had observed various forms of abuse and trauma (including domestic abuse, sexual abuse, childhood trauma and immigration trauma) shaped vulnerability to suicidality over extended periods of time in the lives of people they supported – which were particularly women and children in the context of abuse. We consider different forms of abuse and trauma in this theme because participants described them as sharing a significant role in shaping vulnerability to suicidality over time. This grouping should not be interpreted as suggesting all forms of abuse are the same or equivalent. Rather it reflects the importance participants placed on abuse and trauma – though different in origin, context and extent – in shaping vulnerability to suicidality and how these experiences could also interact with other social factors.

Experiences of domestic abuse were described as leaving individuals living in states of instability and hypervigilance that could gradually reduce people's perceived capacity to cope with daily life, as the quotes below demonstrate:

> Extract 1.3.1: Coercive control can go on for years unseen and is really damaging and linking it to poor mental health … It's that years

and years of insidious creeping control that suffocates somebody's ability to just function, but because it's gradual, they are so far in it before they know it's something that they ought to be doing something about. (SPPV20)

Extract 1.3.2: And the amount of shame and guilt and hopelessness that our clients feel when, for example, they're hugely traumatized by what's happened to them. They may be going through really invasive criminal justice process to try and bring that person to justice, who, because of the criminal justice system, will be out at large in the community with only a legal order to protect them. Which lots of perpetrators don't take any notice of those. So they're feeling constantly hypervigilant and worried about what's going to happen to them looking over their shoulder every 5 min … And for some people, they get to the point where they just can't see a way out. (SPPV20)

Sexual abuse and childhood trauma were similarly described as negatively impacting people's sense of self - of life being worth living – and as creating fear. The negative consequences of childhood trauma were framed as particularly deep and long-lasting by a range of participants. It was described as generating or reshaping exposure to other forms of adversity, including, for example, substance use, experienced later in adulthood and, as a result, heightened vulnerability to suicidality.[2]

Extract 1.3.3: Um, in terms of rape and sexual abuse, it is a huge contributor towards people's mental health [declining]. Um, most people who have encountered sexual abuse of any kind at any point of their life, would feel that it's better not to be here. Would definitely feel that it's better not to be around. (SPPV25)

Extract 1.3.4: Yeah, it is often that childhood trauma that people bury it for a while, but then you often or sometimes see that along the way from that childhood, they're then struggling to cope. You know, it could be drugs, alcohol, self-harm. Um, but then after a while, because if they don't engage with support services, then that could lead on to feeling suicidal because you think, well, I can't put up with this for the rest of my life. Um, or sometimes, you know, we hear that abuse survivors think, oh, I can't trust anybody else anymore. I'm never going to have a relationship. You know, you get a very despairing view of life. (SPPV9)

Evident in extract 1.3.4 is the importance of distrust. In this narrative, distrust seemed to prevent people from building relationships that might otherwise be protective and supportive because of harm wrought by abusers.

With a different emphasis, practitioners highlighted the significance of trauma potentially arising from immigration and asylum seeking, reflecting persecution, violence and displacement:

Extract 1.3.5: It is very obvious that they're vulnerable people. So, they, they're coming in. They've left everything that they, that they understand and that is normal and welcoming to them. Um, and obviously some of them arrive with higher levels of trauma than others. Some have left before they've seen the worst of horrors and some have been through those horrors. [This includes examples of people being] kidnapped and held as a sex slave and exploited and tortured (SPPV5).

Participants also strongly discussed how the instability and bureaucratic complexity embedded in asylum processes in the UK frequently compounded trauma:

Extract 1.3.6: We provide people community, we provide people with resilience so that they can bear to stay alive while they navigate the system, which is probably one of the biggest causes of people feeling suicidal rather than their trauma from their own countries. I would say that the system is probably more triggering than anything that they experienced. (SPPV5)

Overall, participant accounts suggested that experiences of abuse could cast a long shadow over the lives of people who have experienced it. While interaction between trauma and other forms of adversity is explored in more detail in part two, the narratives here demonstrate how experiences of abuse were described as shaping emotional, relational and sometimes material resources available to people when responding to other challenging experiences.

4.4. Theme 1.4: Substance use and gambling

The narratives explored in this theme described substance use and gambling as socially situated responses to disadvantage and adversity that could contribute to vulnerability to suicidality over time. While substance use and gambling are distinct issues with differing social and legal contexts and levels of social normalisation, they are considered together because participants described both as responses to disadvantage and adversity that could increase vulnerability to suicidality. In this regard, we are not suggesting that experiences of substance use and gambling are the same. Rather, this thematic grouping is intended to reflect how participants described both as potentially emerging from other experiences of disadvantage and adversity and as increasing vulnerability over time.

Practitioners revealed that substance use and gambling were part of a complicated picture of vulnerability to suicidality – but rarely as the primary cause of despair. Though alcohol, drugs and gambling were discussed as harmful by our participants – increasing, for example, the likelihood of risky, impulsive behaviours, or creating debt or shame – they were primarily framed as a response to disadvantage and adversity. Substance use was suggested to be a reaction to material instability, abuse and associated emotional distress in the absence of other forms of support. Substance use was relatedly described as a strategy for coping with or escaping from other factors causing despair:

Extract 1.4.1: I mean, it of course varies on an individual basis, but as, you know, from my experience working in this field, I would say the majority of the time it is as a way to cope. Nobody wants to have an issue with substance use. Nobody wants that. So it's often used as a last resort. If somebody's become street homeless, or if everything's kind of falling apart in their life, that might be the one thing that they turn to, to help them cope with it. (SPPV11)

Extract 1.4.2: I think, yeah, it goes back to that coping mechanism and what a lot of people use gambling for. Not everyone, of course, but yeah, quite often there will be, you know, some deep-rooted trauma from childhood or early adolescence that's unresolved or people haven't really had the opportunity to work through. And you know, like any addiction, I guess, it becomes a coping mechanism for that or a way of forgetting about it. (SPPV4)

Gambling was also connected in participant narratives to material insecurity. In the next extract, the participant suggested that gambling harms were more prevalent in deprived areas, where gambling was viewed as a potential route out of hardship:

Extract 1.4.3: What we generally see is areas of higher deprivation, areas with higher diversity tend to show a higher prevalence for gambling harms … Part of that is obviously deprivation and less money. Gambling can be seen as a symbol of hope, and I can bring myself out of this situation or it can help me to a better life. (SPPV4).

[2] We return to a fuller discussion of substance use in a later theme.

Participants also discussed how substance use can be harmful, how it can make circumstances seem even more desperate (e.g. due to withdrawal) or how it might increase the likelihood of engaging in impulsive or risky behaviour:

> Extract 1.4.4: And then if they don't use, they're feeling withdrawal symptoms, physical and mental … we see people that are absolutely at the worst point in their lives and they are so desperate and truly in despair. We see a lot of people here … And because of the nature of the substances as well, if you're using a stimulant that can enhance whatever you are feeling. So if you are feeling really like you're in a bad place and then you use something like crack that can enhance that feeling, um, when you're trying to escape that feeling. So that can actually make you feel worse. (SPPV15)

In this way, vulnerability to suicidality was viewed by some participants as being shaped via withdrawal and intoxication – which was viewed as potentially increasing feelings of despair and impulsive behaviour. However, participants were clear that substance use was not the primary or initial problem:

> Extract 1.4.5: So yes, I think it exacerbates and can make it worse and can make it more likely that someone might take their own life, like to go through with some, to go through with it. Absolutely. But it's not the primary problem. It doesn't, it doesn't cause anything. It's just an attempt to solve a problem in the absence of anything else. (SPPV18)

Overall, practitioners did not generally view substance use or gambling as isolated explanations for suicidality. Instead, they described how these phenomena were situated within wider contexts of disadvantage and adversity, where substance use and gambling could emerge as attempts to distract from or cope with other challenging experiences whilst also potentially contributing to further issues over time in the lives of the people they supported. In this manner, participants described substance use and gambling as part of wider configurations of social factors shaping vulnerability involving experiences such as material insecurity, abuse, isolation and other factors.

4.5. Theme 1.5: Masculinity and gendered expectations

Participant narratives drew attention to the salience of social expectations and norms (particularly relating to gender roles) in influencing vulnerability to suicidality. Participants described how social expectations around perceptions of masculinity in society could influence how other experiences of disadvantage and adversity were interpreted and managed, and could contribute to feelings of shame and failure when people felt unable to live up to dominant expectations attached to masculine roles. Participants reported that feelings of despair often emerged when a man's sense of his own masculinity was challenged by economic circumstances:

> Extract 1.5.1: [I'm] thinking of some of our, our peer volunteers that I've, you know, spent some time with and I know fairly well that have kind of come through it. Yeah, I mean, I think things like … especially for men, like losing your job, losing your home, um, kind of being at that sort of destitute point, like I think that's … you know, it is, it is massive for … particularly for men, um, and, you know, makes you feel worthless and pointless and um, like a failure. (SPPV16)
>
> Extract 1.5.2: But it is a factor in a lot of people's, um, lives where they, they sort of feel emasculated where they can't make their own decisions. They feel, um, that they can't look after their family. Um, that's a very big, um, and where they feel they're letting their family down. Um, that's a huge factor, uh, in, in, in, in a lot of people sort of turning up [to our service], um, is, is the, the emasculation of, of, of what is modern life. (SPPV1)

These narratives highlight how financial insecurity and an inability to provide for family were understood as particularly difficult for some men because of persistent expectations surrounding work, independence and the provider role. Importantly, these narratives suggest that experiences of job loss or material precarity depended not simply on the form of adversity experienced but also on the position an individual occupied in society and the associated expectations attached (in this case gendered expectations). Participants also suggested that when exposure to adverse events occurred, the men they supported in their work found it difficult to talk about their emotions because of societal expectations about strength and resilience that are typically attached to social mores around masculinity:

> Extract 1.5.3: And I think men, I think there is a real, obviously as we know, there's a real problem because men, they're not encouraged to talk about it. And we do a lot of this … [in our work] with trying to break this stigma, um, and, you know, get men talking about their feelings and things like that. But it runs deep, doesn't it? You know, if you've grown up in an environment where it's not safe to do that, you've been shamed, you know, by your dad or something, and it's not that environment, very, very difficult. (SPPV18)

Overall, participants highlighted how norms and values attached to masculinity could shape the ways in which experiences of disadvantage and adversity were interpreted and responded to. Gendered expectations were described as interacting with other social factors (particularly material insecurity but also, as explored in an earlier theme, relationship difficulties) to shape differential consequences, . The gendered expectations attached to masculinity were additionally described as limiting access to emotional support and reducing resources available to men when navigating feelings of despair.

5. Part two

Having examined the specific domains of disadvantage and adversity described by participants in part one above, part two of the analysis now considers more explicitly the cumulative and interconnected nature of vulnerability to suicidality. We begin by examining the layering of adversity, before considering how sustained exposure to disadvantage and adversity can contribute to the escalation of despair over time. The analysis then traces the trajectories through which despair unfolds and vulnerability to suicidality develops, whilst also examining the role of points of crisis within contexts of heightened vulnerability. Together, these themes show how participants understood suicidality as developing over time through processes involving the interaction and accumulation of multiple forms of disadvantage and adversity.

5.1. Theme 2.1: Layers of adversity and the Accrual of despair

Participant narratives generally emphasised that suicidality, in their practice experience, was rarely attributable to singular factors, events or experiences. In other words, vulnerability to suicidality was understood as being shaped by multiple factors and interactions between layers of social, material and relational disadvantage and adversity:

- Extract 2.2.1: So it's really hard to say, but I personally don't think there is a single event … I think it's multifaceted and it's about your ability to cope with that … you know, there's a lack of self-worth. Where does that come from?… So yes, it might look like it on an isolated incident or that it's down to this particular thing, but … You wouldn't have had, you know, resilience. So there's something else that's been at play there to knock you off being able to cope with that or to process it in a way. (SPPV8).

- Extract 2.1.2: Yeah, so, uh, there, there's various aspects of that in terms of the, you know … to answer the question, poverty is huge. You know, people living in, in the most difficult circumstances through all sorts of, um, you know, having reached that point in their lives for lots of different re-, reasons, you know, relationship breakdown or, um, you know, losing their, losing their job or … you know, those, those sorts of things. Um, drugs and alcohol is, is massive (SPPV14)

Not only did participants see suicidality as being generated by layers of exposure, but also often from an *accumulation* of disadvantage and adversity over time. Participants frequently described suicidality as emerging from prolonged exposure to multidimensional strain that had accrued over time:

Extract 2.2.3: You know, it's, if we go kind of go back to that stress bucket, um, analogy is that if that keeps getting overfilled and overfilled, that bucket will just get smaller and smaller and that, that capacity to deal with gets less and less … But I'd say it's the same pressures. It's the same pressures, but just maybe a slightly different intensity for people and people's ability to regulate the self over sustained periods of time. You know, this isn't weeks we're talking, this is months and years for people that have felt this way. (SPPV21)
Extract 2.1.4: I think what, what … I think what happens, particularly with our clients is that they have these incidents of trauma that produce such a lot of stress, anxiety, and tension in their lives that then when other, um, outside, um, determinants happen. So, things like your health gets bad or, you know, your debt rises, or there's some added pressure. That's when we, or I particularly have seen where clients then get to the point where they are actively suicidal or their suicidal ideation, you know, expands, grows. (SPPV26)

Across the extracts presented in this theme, participants described how multiple forms of adversity or disadvantage could accrue. They discussed how the accumulation of these experiences could gradually increase feelings of pressure and despair while diminishing an individual's ability to cope and a sense of alternate positive futures. In this way, vulnerability to suicidality was understood as being shaped not only by exposure to specific forms of disadvantage and adversity but by how these experiences combine and alter the contexts within which other problems or challenges are experienced.

5.2. Theme 2.2: Trajectories of despair

The narratives of our participants revealed examples of what we term 'trajectories of despair.' Building on the previous theme, here we explore how different assemblages of disadvantage and adversity were described as unfolding. Participant accounts included descriptions of configurations of social, material and relational factors described as shaping vulnerability to suicidality. This included material destabilisation trajectories, abuse and enduring harm trajectories, coping and harm escalation trajectories, and institutionally compounded trajectories. It is important to note that these categories are not rigid or mutually exclusive. Within participant accounts, trajectories of despair overlapped and interacted. They are also not necessarily driven by what happened first. However, identifying evidence of configurations helps illuminate the processes through which experiences of disadvantage and adversity accumulated, interacted and became consequential in shaping vulnerability to suicidality temporally.

Material destabilisation trajectories were described as reflecting changes in economic circumstances that could shape a cascading set of consequences across multiple parts of someone's life.

Extract 2.2.1: And then you get made redundant. Because that's what happens sometimes. So, the role that you do gets made redundant, and people often say I was made redundant and it's actually the role, but it feels really personal. So, you've lost your job and which makes you think, well now I can't pay my bills and I can't pay my rent so I'm going to end up, I could end up potentially homeless. And then there's, because you've lost your job, you've lost that community around you and your meaning and purpose something valuable to do, so you try and self-soothe. (SPPV6)
Extract 2.2.2: Yeah, that's the, that's probably the biggest struggle … is, when someone's got more than one thing going on. Maybe they've, maybe they've made, made redundant. Um, because of that, the relationship is starting to struggle. Um, you put those two things into aspect, all of a sudden your finances and work has, has vanished. And then you, where you think your safe place is, is, is, is not, not great either because your relationship, you know, the struggles and, um, that whole pride and, um, feeling embarrassed about it, not wanting to talk about it. Um, and that, that, that's when it becomes that point where if you don't talk about it, that can continue to build up, build up, build up. (SPPV19)

The extracts above, participants described material destabilisation trajectories where job loss was understood as having wide-ranging consequences beyond only loss of earnings. Redundancy was described as impacting and reshaping multiple areas of life including identity and purpose, housing, social connection, relationships and beyond. Here we can see how one set of experiences could interact with and reshape the social, material and relational context in which other challenges developed.

A second configuration identified within participant accounts reflected what we term abuse and enduring harm trajectories. Experiences of abuse and trauma were described as having long-lasting consequences that reshaped how other forms of disadvantage and adversity were encountered and experienced.

Extract 2.2.3: So, more people are taking their own lives due to domestic violence, rather than being murdered by a partner or ex-partner, which is horrible … So, if you've been, if you are experiencing economic abuse as part of that domestic abuse, so then you can't get connected online. So, then you can't get the support you need. Plus, abusers isolate you and restrict your access to support and to family members and to friends. So, all of those previous problems, isolation, loneliness, economic instability, lack of digital access plus being abused. It's understandable why people reach the end of their tether and think there's only one way to escape this. (SPPV6)

In extract 2.2.3. SPPV6 described an abuse and enduring harm trajectory in which experiences of abuse were restricting access to support, increasing isolation and created a range of associated problems for someone being abused that can compound and multiply. Ultimately, emotional exhaustion, hopelessness and narrowing of the lifeworld was described as eroding alternative visions of the future.

A third configuration – that we termed institutionally-compounded trajectories – reflected how interactions with services and systems could intensify experiences of disadvantage and adversity rather than alleviating despair.

Extract 2.2.4: Um, we understand any incident of sexual abuse as part of a continuum of violence. So it is, nothing is isolated … So, when we think about, um, sexual abuse, rape, or any type of sexual assault, it does belong in particularly in the lives of women and girls within a continuum of violence. And part of that continuum of violence could be institutional violence in terms of like not addressing their needs, not being able to take cases to court, the failures in the criminal justice system, but also the failures of the statutory services on addressing the mental health concerns. Um, so we end up in [our service] receiving these people saying 'my mental health is really poorly. Um, I got this issue, this issue, this issue, this

issue, this issue, this issue. Plus, I have gone through this incident of sexual abuse, and no one hears me. (SPPV25)

In extract 2.2.4, SPPV25 discussed how experiences of abuse could be compounded by the perceived failings of institutions and systems intended to help. This extract illustrates how institutional responses can become a source of harm that reshapes the context in which individuals have attempted to manage or move beyond experiences of adversity.

A fourth configuration we termed coping and harm escalation trajectories. Participants described how substance use and gambling – as strategies to manage or escape other forms of disadvantage or adversity – could become interwoven with challenges and additional difficulties over time.

Extract 2.2.5: But generally, you know, when people get to, you know, the stage where they're contemplating suicide or self-harming, gambling has had such an impact where it's affected every area of their life, you know, from their money to their career, to their physical health, their mental health, their relationships, their work and study. (SPPV4)
Extract 2.2.6:… from what I've seen, and I have seen, you know, people spiralling into this situation where they … their lives become more and more complex. Their drug use increases or their alcohol use increases, and it might not even be recorded as suicide, but they have ended up killing themselves with those, with those, um … that they use because they just … there's no … there doesn't seem to be any way out. (SPPV14)

In these extracts, participants described how substance use and gambling could become embedded within and reshape trajectories of despair. Rather than representing isolated causes, experiences of substance use and gambling were framed as coping mechanisms that could subsequently reshape life circumstances by producing other social, material and relational challenges.

5.3. Theme 2.3: Points of crisis

In the narratives of participants, it was clear that as disadvantage and adversity accumulated – and despair deepened – specific events functioned as points of crisis. It is here that we can see the differential consequences that develop from differential vulnerability – or the interplay of social position and the range of exposures revealed earlier in the analysis. It is at this point in trajectories of despair that participants described vulnerability to suicidality as heightened, including the emergence or intensification of suicidal ideation and, in some cases, movement towards suicidal behaviour.

Extract 2.3.1: We use a very simple, uh, process to try and explain to people, we call it the stress bucket. That all of these things get put in and, you know, individually or with a couple of them, largely, people can manage those stresses without becoming too much. When you have lots of those things all at once and you have no way of releasing that valve, then yeah. That's what we suggest would become the tipping point. (SPPV12)[3]

Points of crisis – where vulnerability was most heightened – were described as seemingly taking a variety of forms (that relate to the range of interconnected social factors that we have discussed throughout the analysis):

Extract 2.3.2: Um, so the kind of post-trauma things that would layer up … Um, but then it would be things like debt. It would be breakdown of relationship, it would be domestic abuse, um, it would be, uh, housing issues. Um, so just the stress, I mean, the stress of moving house is one of those, the big kind of known stresses in life… But that on top of, you know, moving house and having to work out the council processes and stuff and trying to get into the council accommodation on top of everything else sometimes would tip people to the point where they're, yeah, no longer able to cope. (SPPV26)
Extract 2.3.3: I think, I think when it tips over the edge. So, if you're poor, you're poor. And you know how much money you're getting in every month. Because you may be having to survive on disability benefits or a very, very low income and you kind of know what it is. And that's what you've got. It's when there's another change on top of that when, when there's a crisis as well. So being poor is rubbish, but being poor and having a crisis as well tips you over. It's not the being poor in the first place that makes you more vulnerable to, to thoughts of suicide in my experience. Um, it's the crisis on top of it. It's the breakdown of the relationship. It's being evicted, being made redundant. Those additional stressors on top of the, the baseline of, you know, just about getting by. (SPPV6)

Participants also described how an inability to access sufficient support during a critical moment could lead to a suicide attempt in itself:

Extract 2.3.4: If anything, on my experience of working with survivors of rape and, and sexual abuse, I will say, uh, what makes someone take that decision is, when they hear nothing at the other end of the phone. And at the moment, more and more services … are putting those phones down, because I'm not saying like literally putting their phones down, but the amount of long-term support for those people feeling in those low moments is less and less and less. So, I think that's a determinant … It's like when I ask for help, does someone listen? And if they're not listening, it's more likely that, I am confirming what's the point. (SPPV25)

In the extracts presented in this theme, participants described points of crisis happening on top of layers of disadvantage and adversity. In this way, points of crisis do not represent a causal event, but represent the point where people feel unable to cope with or escape from varying combinations of material, social and relational pressures. In other words, vulnerability to suicidality was described as emerging through the relationship between immediate crisis and broader trajectories of despair. It can be seen as the point at which a sense of the future or alternative trajectories no longer seem viable to the person experiencing despair. Though what represents the points of crisis varies depending on the situation, this theme has revealed the differential consequences that emerge from the interplay between the social forces discussed earlier in the analysis and the development of suicidal ideation or behaviour.

6. Discussion

The data analysed in this paper demonstrates how a range of established social determinants of suicidality (see Gallagher et al., 2025; Na et al., 2025; Pirkis, Bantjes, et al., 2024, Pirkis, Bantjes, et al., 2024) interact and accumulate to shape vulnerability over time. This included experiences of deprivation (see Camacho et al., 2024; Price et al., 2024), isolation and disconnection (see Blázquez-Fernández et al., 2023), abuse and trauma (Angelakis et al., 2019; Dworkin et al., 2022), social position and gender norms (see Galvez-Sánchez et al., 2024), as well as providing further evidence about the nature of the connection between substance use and suicidality (see Beseran et al., 2022; Pirkis, Dandona, et al., 2024) and gambling and suicidality (Marionneau & Nikkinen, 2022).

[3] The stress bucket metaphor was used by a small number of participants during interviews. It seemed to reflect a practice-based framework through which the accumulation of disadvantage and adversity – and the subsequent emergence of points of crisis – was conceptualised. Here we can see how practitioner accounts may be shaped by professional training or organisational contexts. As such, this framing may not necessarily capture how people with lived experience of suicidality understand or describe similar processes.

The narratives of participants have shown how exposure to these social factors can shape despair by eroding feelings of hope and a sense of choice or a liveable future, depleting emotional resources or buffers, constraining relationality and feelings of support, and increasing the likelihood of impulsive or risky behaviour. In this way, our work supports an understanding of vulnerability (in this case to suicidality) as socially contingent and shaped by social phenomena (Brown, 2021). This approach suggests that vulnerability emerges through differential exposure to disadvantage and adversity and differences in the resources and contexts available to respond to these experiences – rather than being a fixed characteristic of certain individuals or groups. In other words, though specific groups are not inherently more vulnerable to suicidality, the compounded social, material and relational conditions that people experience can shape their respective vulnerability to suicidality.

Practitioner accounts widely framed suicidality as emerging through processes of differential exposure and differential vulnerability to disadvantage and adversity. The conceptual framework developed by Diderichsen and colleagues' that we have used in this paper suggests that people hold unequal social positions, and that those holding lower social positions are differentially exposed to health harming factors and are differentially vulnerable due to the cumulative impact of disadvantage and adversity. Regarding social position, practitioners described a context in which economic insecurity, rising living costs and unemployment/unstable work are highly consequential. However, exposure to a specific form of material insecurity *alone* was rarely seen as sufficient to explain suicidality. Instead, consistent with other work (see Fincham et al., 2011) it was the accumulation and interaction of exposures over time (often alongside critical life events such as relationship breakdown) that created the conditions in which despair deepened and vulnerability to suicidality increased. Similarly, though participants described the importance of points of crisis this was generally framed as the moment where disadvantage and adversity had accumulated to such an extent that an individual felt unable to cope, rather than as a causal incident.

A range of social and biographical factors mediated how adults experienced and responded to material insecurity and heightened vulnerability to suicidality. Gender norms were often discussed by practitioners, especially in relation to expectations of self-reliance, emotional control and economic provision, as well as in relation to coercive control and violence. For some men, gender expectations appeared to intensify vulnerability where wider material or relational issues were also at play. Abuse and trauma were also described as consequential and as reducing emotional, relational and possibly material buffers against the world. Meanwhile, social isolation, whether through fractured family relationships, limited community ties, or issues associated with service access, further heightened vulnerability by reducing opportunities for emotional support and early intervention. Finally, participants also clearly identified connections between material insecurity and substance use and gambling – which were described as ways to escape or distract from the wider circumstances of their lives but that could increase risky or impulsive behaviours. Similar connections between material circumstances, subsequent hopelessness and substance use as a coping mechanism have been identified in other work (Price et al., 2024).

As a result of these kinds of dynamics, the consequences of exposure and vulnerability were described as unevenly distributed. Practitioner accounts identified that while many individuals in society experience deprivation, insecure housing, and beyond, this only leads to suicidal ideation or behaviour in some, not all people. Where suicidality did emerge, it was often described as the endpoint of a prolonged process in which repeated adversity and unmet needs compounded feelings of structural entrapment and hopelessness. Importantly, the findings suggest that suicidality was less a direct response to any single adverse event than a reflection of how multiple forms of disadvantage converged and were experienced as inescapable by individuals. This is compatible with other work that has described how ongoing, normalised social and material pressures gradually erode people's capacity to cope, helping to explain suicidality as the outcome of cumulative harm rather than a response to isolated events (Chandler & Wright, 2024).

It is here that our concept of 'trajectories of despair' offers additional explanatory power when analysing the social determinants of suicidality. We utilised the idea of trajectories of despair to explain how vulnerability to suicidality is a process that tends to unfold and expand gradually over a temporal frame. It captures how suicidality was framed as a process that took shape differently depending on the combination and timing of the issues people faced, rather than as a single endpoint reached through the same route. The configurations identified in this paper – material destabilisation trajectories, abuse and enduring harm trajectories, coping and harm escalation trajectories, and institutionally compounded trajectories – demonstrate some of the interactional and cumulative processes through which vulnerability to suicidality can develop. These trajectories should not be understood as rigid pathways – but rather as examples of how different combinations of social, material and relational disadvantage and adversity can become consequential over time. In other words, vulnerability to suicidality can be understood as changing temporally as different configurations of disadvantage and adversity accumulate, interact and reshape the social, material and relational contexts in which subsequent challenges are experienced, while contributing to diminishing the resources available to individuals to cope with or respond to these challenges. However, it is important to note that our data does not allow us (nor do we wish) to establish distinct stages of suicidality. Indeed, many of our participants declared this to be very difficult to establish. Further research might conceivably draw on the concept of trajectories of despair to refine and extend these preliminary configurations, including through longitudinal or life course analyses, and research centred on the lived experiences of suicidality.

6.1. Limitations

This study draws on the perspectives of third sector practitioners and does not include interviews with individuals with lived experience of suicidality. As such, the findings do not constitute first-person accounts of suicidality. The focus on practitioner narratives enabled analysis across multiple cases and service contexts, offering insight into patterns of vulnerability and the ways in which suicidality and prevention are understood, interpreted and managed over time. However, the narrative accounts of suicidality generated in this study are situated within particular organisational and professional contexts. In this regard, practitioner interpretations that are shaped by a range of possible factors including disciplinary background, training, organisational values and their own professional and personal experiences and perspectives. In this regard, it is possible that practitioners emphasised forms of disadvantage and adversity that are most apparent in the populations they support, or that reflect the interpretative frameworks associated with their roles, training or disciplinary background. Additionally, while third sector practitioners engage with a diverse range of individuals and circumstances in their work, they cannot reveal the experiences of people who do not disclose suicidality or with whom they never have service contact. Therefore, the findings should be interpreted as practitioner understandings of the social factors and processes associated with suicidality, rather than as providing direct access to lived experiences of suicidality.

In addition, the study focused primarily on third sector provision and does not include statutory mental health services. The absence of NHS crisis service professionals and other clinicians in the sample means that we captured only part of the suicide prevention landscape and cannot fully address how crisis is understood within formal emergency pathways. However, our focus enabled particular attention to perspectives associated with pre-crisis, community-based and relational forms of support that are often less visible.

7. Conclusion

This paper has produced a narrative understanding of the social determinants of suicidality. We have done this by drawing on qualitative interview data generated with suicide prevention practitioners and other relevant third sector practitioners. By deploying the concept of differential vulnerability (see Diderichsen et al., 2001, 2012, 2019), we have examined the processes through which social, material and relational factors combine and compound to shape suicidality over time within trajectories of despair.

Ethics

A favourable opinion for the research to begin was awarded by Ethics Sub Committee 1 at the University of Essex in May 2025 (application number: ETH2425-0815. All participants were given an information sheet, and they were told that participant was voluntary. All participants signed a consent form prior to their interview. All interviews were audio recorded using a digital voice recorder and transcribed verbatim with the consent of participants. An external transcription company – with whom we arranged a non-disclosure agreement prior to sharing our audio recordings – transcribed the data.

Data statement

Given the nature of the topic, some extremely sensitive and potentially identifiable stories were shared with us during the research. Upon completion of data analysis, it was decided that the full dataset should not be made publicly available.

Declaration of generative AI and AI-assisted technologies in the writing process

During manuscript drafting and revision, the authors used CoPilot and ChatGPT for word/phrasing suggestions and to enhance readability. AI was NOT used to review literature, analyse data or in any other facet of the work. Following the use of these tools, the authors have carefully reviewed and edited the content and take full responsibility for the final version of the publication.

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CRediT authorship contribution statement

Tom Douglass: Conceptualization, Formal analysis, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing. **Ewen Speed:** Conceptualization, Formal analysis, Methodology, Writing – review & editing.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Tom Douglass and Ewen Speed report financial support was provided by National Institute for Health and Care Research as part of HDRC Greater Essex.

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References

Anderson, L. R., Monden, C. W. S., & Bukodi, E. (2022). Stressful life events, differential vulnerability, and depressive symptoms: Critique and new evidence. *Journal of Health and Social Behavior, 63*(2), 283–300. https://doi.org/10.1177/00221465211055993

Angelakis, I., Gillespie, E. L., & Panagioti, M. (2019). Childhood maltreatment and adult suicidality: A comprehensive systematic review with meta-analysis. *Psychological Medicine, 49*(7), 1057–1078. https://doi.org/10.1017/S0033291718003823

Bantjes, J., & Swartz, L. (2019). "What can we learn from first-person narratives?" the case of nonfatal suicidal behavior. *Qualitative Health Research, 29*(10), 1497–1507. https://doi.org/10.1177/1049732319832869

Beseran, E., Pericàs, J. M., Cash-Gibson, L., Ventura-Cots, M., Porter, K. M. P., & Benach, J. (2022). Deaths of despair: A scoping review on the social determinants of drug overdose, alcohol-related liver disease and suicide. *International Journal of Environmental Research and Public Health, 19*(19), Article 12395. https://doi.org/10.3390/ijerph191912395

Blázquez-Fernández, C., Lanza-León, P., & Cantarero-Prieto, D. (2023). A systematic review on suicide because of social isolation and loneliness: Does COVID-19 make a difference? *Journal of Public Health, 45*(3), 680–688. https://doi.org/10.1093/pubmed/fdad001

Brown, P. (2021). *On vulnerability: A critical introduction*. Routledge.

Butt, S., Randall, E., Morris, S., Appleby, L., Hassiotis, A., John, A., McCabe, R., & McManus, S. (2025). Suicidal thoughts, suicide attempts and non-suicidal self-harm. In S. Morris, S. Hill, T. Brugha, & S. McManus (Eds.), *Adult psychiatric morbidity survey: Survey of mental health and wellbeing, England, 2023/4*. NHS England. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm.

Camacho, C., Webb, R. T., Bower, P., & Munford, L. (2024). Risk factors for deaths of despair in England: An ecological study of local authority mortality data. *Social Science & Medicine, 342*, Article 116560. https://doi.org/10.1016/j.socscimed.2023.116560

Case, A., & Deaton, A. (2020). *Deaths of despair and the future of capitalism*. Princeton, NJ: Princeton University Press.

Chandler, A., Anderson, J., Helman, R., Huque, S., & Yue, E. (2022). Reimagining suicide research: The limits and possibilities of suicide cultures. *Social Epistemology Review and Reply Collective, 11*(10), 20–28. https://wp.me/p1Bfg0-7gK.

Chandler, A., & Wright, S. (2024). Suicide as slow death: Towards a haunted sociology of suicide. *The Sociological Review, 72*(5), 1038–1056. https://doi.org/10.1177/00380261231212764

Cohen, L. J., Mokhtar, R., Richards, J., Hernandez, M., Bloch-Elkouby, S., & Galynker, I. (2022). The narrative-crisis model of suicide and its prediction of near-term suicide risk. *Suicide and Life-Threatening Behavior, 52*(2), 231–243. https://doi.org/10.1111/sltb.12816

Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. World Health Organization.

Dannefer, D. (2003). Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 58*(6), S327–S337. https://doi.org/10.1093/geronb/58.6.S327

Department of Health. (2012). *Preventing suicide in England: A cross-government outcomes strategy to save lives*. Department of Health. https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england.

Department of Health and Social Care. (2023). *Suicide prevention in England: 5-year cross-sector strategy*. GOV.UK. https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy.

Diderichsen, F., Andersen, I., Manuel, C., & Working Group of the Danish Review on Social Determinants of Health. (2012). Health inequality – Determinants and policies. *Scandinavian Journal of Public Health, 40*(8), 12–105. https://doi.org/10.1177/1403494812457734

Diderichsen, F., Evans, T., & Whitehead, M. (2001). The social basis of disparities in health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya, & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action* (pp. 12–23). Oxford University Press.

Diderichsen, F., Hallqvist, J., & Whitehead, M. (2019). Differential vulnerability and susceptibility: How to make use of recent developments in our understanding of mediation and interaction to tackle health inequalities. *International Journal of Epidemiology, 48*(1), 268–274. https://doi.org/10.1093/ije/dyy167

Durkheim, E. (1951). *Suicide: A study in sociology*. J. A. Spaulding & G. Simpson, Trans.). Free Press. (Original work published 1897).

Dworkin, E. R., DeCou, C. R., & Fitzpatrick, S. (2022). Associations between sexual assault and suicidal thoughts and behavior: A meta-analysis. *Psychological Trauma. Theory, Research, Practice, and Policy, 14*(7), 1208–1211. https://doi.org/10.1037/tra0000570

Fincham, B., Langer, S., Scourfield, J., & Shiner, M. (2011). *Understanding suicide: A sociological autopsy*. Palgrave Macmillan.

Forrest, L. N., Beccia, A. L., Exten, C., Gehman, S., & Ansell, E. B. (2023). Intersectional prevalence of suicide ideation, plan, and attempt based on gender, sexual

orientation, race and ethnicity, and rurality. *JAMA Psychiatry, 80*(10), 1037–1046. https://doi.org/10.1001/jamapsychiatry.2023.2295

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*. https://doi.org/10.1186/1471-2288-13-117. Article 117.

Gallagher, K., Phillips, G., Corcoran, P., Platt, S., McClelland, H., O'Driscoll, M., & Griffin, E. (2025). The social determinants of suicide: An umbrella review. *Epidemiologic Reviews, 47*(1), mxaf004. https://doi.org/10.1093/epirev/mxaf004

Galvez-Sánchez, C. M., Camacho-Ruiz, J. A., Castelli, L., & Limiñana-Gras, R. M. (2024). Exploring the role of masculinity in male suicide: A systematic review. *Psychiatry International, 6*(1), 2. https://doi.org/10.3390/psychiatryint6010002

Kessler, R. C. (1979). A strategy for studying differential vulnerability to the psychological consequences of stress. *Journal of Health and Social Behavior, 20*(2), 100–108. https://doi.org/10.2307/2136432

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior, 35*, 80–94. https://doi.org/10.2307/2626958

Marionneau, V., & Nikkinen, J. (2022). Gambling-related suicides and suicidality: A systematic review of qualitative evidence. *Frontiers in Psychiatry, 13*, Article 980303. https://doi.org/10.3389/fpsyt.2022.980303

Marzetti, H., McDaid, L., & O'Connor, R. (2023). A qualitative study of young people's lived experiences of suicide and self-harm: Intentionality, rationality and authenticity. *Child and Adolescent Mental Health, 28*(4), 504–511. https://doi.org/10.1111/camh.12602

McClelland, H., Evans, J. J., & O'Connor, R. C. (2022). A qualitative exploration of the experiences and perceptions of interpersonal relationships prior to attempting suicide in young adults. *International Journal of Environmental Research and Public Health, 19*(13), 7880. https://doi.org/10.3390/ijerph19137880

Na, P. J., Shin, J., Kwak, H. R., Lee, J., Jester, D. J., Bandara, P., Kim, J. Y., Moutier, C. Y., Pietrzak, R. H., Oquendo, M. A., & Jeste, D. V. (2025). Social determinants of health and suicide-related outcomes: A review of meta-analyses. *JAMA Psychiatry, 82*(4). https://doi.org/10.1001/jamapsychiatry.2024.4241

O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences, 373*(1754), Article 20170268. https://doi.org/10.1098/rstb.2017.0268

Office for National Statistics. (2025). *Suicides in England and Wales: 2024 registrations*. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2024registrations.

Pirkis, J., Bantjes, J., Dandona, R., Knipe, D., Pitman, A., Robinson, J., … Hawton, K. (2024). Addressing key risk factors for suicide at a societal level. *The Lancet Public Health, 9*(10), e816–e824.

Pirkis, J., Dandona, R., Silverman, M., Khan, M., & Hawton, K. (2024). Preventing suicide: A public health approach to a global problem. *The Lancet Public Health, 9*(10), e787–e795.

Polling, C., Woodhead, C., Harwood, H., Hotopf, M., & Hatch, S. L. (2021). "There is so much more for us to lose if we were to kill ourselves": Understanding paradoxically low rates of self-harm in a socioeconomically disadvantaged community in London. *Qualitative Health Research, 31*(1), 122–136. https://doi.org/10.1177/1049732320957628

Price, T., McGowan, V., Vishram, S., Wildman, J., & Bambra, C. (2024). "They're not mentally ill, their lives are just shit": Stakeholders' understanding of deaths of despair in a deindustrialised community in North East England. *Health & Place, 90*, Article 103346. https://doi.org/10.1016/j.healthplace.2024.103346

Singer, M., Bulled, N., Ostrach, B., & Mendenhall, E. (2017). Syndemics and the biosocial conception of health. *The Lancet, 389*(10072), 941–950. https://doi.org/10.1016/S0140-6736(17)30003-X

Walker, T., Wainwright, V., Dunlop, B. J., Forrester, A., Senior, J., & Shaw, J. (2022). A qualitative exploration of the views of people with lived experience of suicide within the criminal justice system. *Journal of Forensic Psychiatry and Psychology, 33*(6), 868–882. https://doi.org/10.1080/14789949.2022.2149418

Zhu, Y., Nam, S., Quan, L., Baek, J., Jeon, H., & Tang, B. (2022). Linking suicide and social determinants of health in South Korea: An investigation of structural determinants. *Frontiers in Public Health, 10*, Article 1022790. https://doi.org/10.3389/fpubh.2022.1022790