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Men, mental health, and suicide

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Men, mental health, and suicide

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Editorial: Men, mental health, and suicide

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Editorial on the Research Topic
Men, mental health, and suicide

Suicide has been identified by the World Health Organisation (2014) as a global health problem disproportionately impacting males. Various psychosocial and neurobiological explanations have been advanced to account for the high rates of suicide in men including unwillingness to engage in mental health help-seeking, lack of gender-sensitive mental health services, impulsivity, alcohol and drug use, and access to and use of lethal means. A cultural/gender perspective has proved insightful in describing how gendered pressures and cultural beliefs about the idealized characteristics and practices of men can heighten the risks for suicide. Cultural/gender explanations are supported by the fact that rates of male suicide vary considerably across the world and fluctuate within societies between sub-groups of men based on socioeconomic status, race/ethnicity, age, sexuality, urban/rural location and or the intersection of these factors. The focus of this Research Topic is on men's mental health, how men respond to mental health challenges and make decisions relating to suicidality. The collection of papers includes contributions from a variety of disciplines and are based on diverse research populations in Europe, the United States and Australia.

Streb et al. begin the discussion by addressing the male excess in suicide rates and the discrepancy between men's low rate of diagnosed depression and high rates of suicide. A possible explanation for this finding is that current depression inventories do not capture typical male symptoms of depression (Martin et al., 2013) and the authors examined gender-specific differences in depression symptoms between men and women in a forensic psychiatric sample. Although externalizing behaviors were similar in both groups, they found a significant relationship between external and internal depression symptoms only in men. This confirms previous research indicating unique symptomology in depressed men characterized by aggressiveness, alcohol use, and risky behavior (Möller-Leimkühler and Mühleck, 2020). These are significant risk factors for suicidal behavior (Rice et al., 2019; Armstrong et al., 2020) and the authors advocate the use of gender-sensitive screening instruments for the early detection of depression symptoms in men.

In terms of identifying suicidal features, practices of restrictive emotionality are identifiable in some, but not all, men. As Gough et al. demonstrate, men disclose difficulties, including anxiety, in safe environments such as therapeutic settings and within intimate partner relationships as well as to male friends. Men's emotion disclosures are also impacted by the ability of others to recognize and empathically engage in such talk in ways that are consistent with the way they create ideals for themselves by using elements of hegemonic masculinity that

they value and that they can attain (Griffith, 2022). The analysis highlights how men's anxiety-talk and help-seeking is embedded in and often constrained by interpersonal relationships and social interactions (Evans et al., 2011). Vickery's paper similarly demonstrates the ability of men to disclose emotional problems and the findings imply diversity in how men engage with their mental health and seek help. According to Vickery, the study participants demonstrated that men can embrace alternative patterns of masculinity which enable them to positively engage with their mental health.

Trail et al. continue this exploration of masculinities and health related practices in a rural Australian community. Rural Australian men have a higher risk of dying by suicide and this is frequently linked to their adherence to messages and pressures associated with a tough kind of masculinity and remaining stoic in the face of hardship. Based on qualitative interviews with community workers they identify key areas for understanding suicide risk for these rural men. The contribution of local expressions of masculinity to men's wellbeing and help-seeking behaviors were viewed as key challenges as these men felt pressure to adhere to idealized roles and values. Referenced also were men's disconnections which led to loneliness and isolation that fed their distress and increased suicide risk.

Grigienė et al.'s study focuses on gender identity and suicide risk in Lithuanian men. The findings of their quantitative inquiry showed that higher gender self-definition and higher gender self-acceptance were associated with lower suicide risk and the authors concluded that a stronger gender self-confidence is an important protective factor in relation to male suicide. Accordingly, the authors conclude that while some aspects of masculinity increase suicide risk, therapeutic strategies targeted at bolstering strength-based masculinity are important.

Valdez et al. continue the exploration of different masculinities and the need for place-based health assessments in detailing the challenges of low/no-income Latino men. Based on findings from in-depth interviews with Puerto Rican men living in the United States, their results reveal that participants linked stress to factors such as experiences of racism and prejudice, family relationships, and lack of economic and other resources and also to histories of colonial violence and displacement. The authors propose expanding standardized assessment models to delineate the impact of distinctive historical trajectories to assist in interpreting racial/ethnic health inequities and thus improve interventions.

Two papers explore important sites, the family and school, for the development of gender identity and masculinity values. Cleary explores the implications for men's wellbeing of exposure to family and neighborhood cultures of feeling restriction and the contribution of fathers and father-son relations to these environments. The inquiry, based on a sample of men who made a suicide attempt in adulthood, revealed how exposure to a hegemonic form of masculinity from an early age - such as adhering to masculine values emphasizing strength and emotional stoicism - restricted the respondents in learning about and negotiating the emotional issues of their lives and led to problematic father-son relationships. The study demonstrated challenges for males raised in settings that value rigid forms of hegemonic masculinity and the importance of nurturing father-son relationships for male wellbeing. Wilson et al. also cite the influence of the father on young males in their exploration of teachers' and parents' perspectives on masculinities in a single-sex independent Australian school. Results indicate the impact of Australian masculinity norms and the role of private boys' school cultures in the development of adolescent masculinities but also perceptions of public and private masculinities and the need to upskill parents, particularly fathers, in their capacity to model healthy masculinity norms.

Overall, the Research Topic highlights the existence of diverse masculinities and male mental health-related practices and the need for place-based approaches to prevent suicide. As Balcombe and De Leo suggest, more needs to be known about the complex relationship between mental ill-health, its comorbidities and the biopsychosocial factors that influence suicidality but identifying the contexts in which men can safely share their experiences is key and localized interventions offer the best possibility of success in preventing male deaths by suicide.

Author contributions

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Engendered Expressions of Anxiety: Men's Emotional Communications With Women and Other Men

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While the contemporary therapeutic discourse inveigles us to talk about our personal problems, a countervailing neo-liberal healthist discourse, aligning with conventional masculinity norms, presumes that we will manage any issues independently. This discursive tension can be difficult to navigate, especially for men confronted with still powerful traditional expectations around masculinity (e.g., self-reliance; personal control; restricted emotionality). Although qualitative research has examined how men negotiate masculinities with respect to depression, to date there has been scant attention focused on men experiencing anxiety. This article reports on an interview study with men, some with anxiety diagnoses and some without (N = 17). Thematic analysis highlights that participants can and do talk about their anxieties, most readily with significant women in their lives (e.g., partners; mothers)–although this is not always straightforward. Talking to other men was more fraught, and while participants were wary of sharing problems with male friends, or signaled issues indirectly, they also highlighted situations where they would open up e.g., workspaces where they felt safe; with best friends. Those who had gone through a therapeutic process over many years tended to me more comfortable talking to others, male or female, about their mental health–and were also keen to other support to others where they could. Our analysis suggests that despite stereotypical notions of silent, self-contained men, there are many contexts where men may feel comfortable sharing their stories of pain and suffering. This chimes with wider cultural changes and the reported experiences of some mental health initiatives.

Keywords: anxiety, emotional communication, men, masculinity, interviews, thematic analysis, men and masculinity

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INTRODUCTION

According to the 2013 Global Burden of Disease study, anxiety is the second most commonly diagnosed mental health problem worldwide (Vos et al., 2013), with approximately 264 million people thought to suffer from anxiety globally (World Health Organization (WHO), 2017). While globally, depression remains the most commonly identified mental health problem (World Health Organization (WHO), 2018), other statistics suggest comorbid diagnoses of anxiety and depression to be the most commonly diagnosed condition in the United Kingdom (NICE, 2011), with anxiety disorders representing the second most commonly diagnosed mental health problem (McManus et al., 2016). Either way, it is clear that anxiety affects a large number of individuals living in the United Kingdom (and beyond).

Gender differences in the statistics relating to mental health are widely recognised, with women understood to be twice as likely to be diagnosed with an anxiety disorder or depression throughout

their lives (Remes et al., 2016). Researchers have suggested that the lower prevalence rates of common mental health problems in men do not mean that men experience depression or anxiety less overall. Rather, their expressions of symptoms are constrained by hegemonic masculinities that privilege practices such as self-reliance and restrictive emotionality (Addis and Mahalik, 2003; Mahalik and Rochlen, 2006; Robertson et al., 2016). Given the association between depression and suicide (Zhang and Li, 2013; Luo et al., 2016), it is perhaps unsurprising that the overwhelming majority of research has focused on how men experience and manage depression (e.g., Oliffe et al., 2016; Lee et al., 2017; Seidler et al., 2018). This focus has meant that other important common mental health problems, particularly anxiety, have been relatively unexplored in gender and mental health research. Recent research on changing masculinities, emotion and vulnerability suggests that, despite persistent stereotypes of emotionally repressed men, there are circumstances where some men may be willing to talk about their fears and anxieties. For example, certain online environments like discussion forums can enable men to (anonymously) share their distress and receive support from peers with similar experiences e.g., depression, infertility (e.g., Gough, 2016; Hanna and Gough, 2016). In fact, recent research by Drioli-Phillips et al. (2020a), Drioli-Phillips et al. (2020b) has examined how men talk to each other about anxiety online and highlights the importance of presenting credible accounts, with anxiety characterised as loss of control.

Mental health support online can also target particular communities of men e.g., from ethnic and sexual minority groups (e.g., the British Punjabi community: http://www.taraki.uk/male-mental-health). Offline, a range of community initiatives targeting men, often activity-based, have been implemented (see Robertson et al. 2016), perhaps the best known being the "Men's Sheds" initiatives bringing older isolated men (and increasingly other groups of men) together to work on practical projects and develop bonds (e.g., Ballinger et al., 2009). Here, the emphasis is on indirect, "shoulder-to-shoulder" support in a friendly environment. But there are also some initiatives encouraging men to directly share their mental health problems with other men, face-to-face (e.g., Andy's Man Club: https://andysmanclub.co.uk/)–an interesting development considering men's supposed horror of "just talking" about their emotional difficulties and perhaps signaling a shift toward a softer, more caring and emotionally intelligent masculinity.

Aside from seeking and/or receiving support from peers within designated spaces and programmes, literature on (heterosexual) interpersonal relationships suggest that men may be somewhat comfortable disclosing to female partners, within limits (e.g., Holmes, 2015). In a study exploring the interplay between discourses of "big boys don't cry" and "it's good to talk", McQueen (2017) found tensions for men surrounding the need to disclose in intimate relationships and a gendered preference toward remaining self-reliant. With some younger men, mothers may be pivotal in enabling self-disclosure (Wirback et al., 2018). Robertson (2007), however, reminds us of the dangers of over-emphasising the role that significant female others may have, arguing that placing the burden of men's emotional well-being on women removes responsibility from men in effecting positive changes for themselves. As for men's friendships with other men, the literature largely focuses on notions of competition, policing and social comparison whereby traditional masculinities are enacted and perpetuated (e.g., Kimmel, 1994). However, recent theory and research points to a loosening of such expectations. If we consider the body of research underlying Anderson's inclusive masculinity theory, for example, it is reported that young, middle-class, white men are engaging in more emotionally expressive forms of friendship (see Anderson, 2008; Anderson and McGuire, 2010; Adams, 2011). In terms of mental health issues, however, little is known about how men might expose their difficulties to male friends and peers.

Recognising the gap in research on men's anxiety, this article seeks to understand more about how men construct and negotiate everyday and significant anxiety experiences. In particular, we were interested in men's accounts of help-seeking and self-disclosure in the context of anxiety, and in identifying situations and relationships where men felt most comfortable sharing their worries.

MATERIALS AND METHODS

Initially, our intended focus was on men with a current diagnosis of Generalised Anxiety Disorder (GAD). Considered a chronic disorder (Yonkers et al. 2000), GAD is generally characterised by excessive, persistent and disruptive worries that are not restricted to particular events or situations (Lader, 2015), as well as other physically disruptive symptoms (Cuijpers et al., 2014). However, after searching for literature pertaining to men and anxiety, there were few results. There also appeared to be no direct or sustained gendered discussion of anxiety, either as an emotion in its own right or as a mental health issue. GAD is very rarely diagnosed alone, most commonly being diagnosed in relation to a wide spectrum of other disorders (Wittchen et al., 1994), such as panic disorder and social anxiety (Yonkers et al., 1996), bipolar disorder (Pavlova et al., 2015) and major depressive disorders (Spitzer et al., 2006). As such, it was decided to open up the inclusion criteria to participants with a mental health diagnosis in order to include a wide range of anxiety disorders and comorbidity with depression. The study therefore addressed how anxiety is managed in everyday (non-pathologised) contexts as well as in relation to GAD, thereby garnering a rounded view of men's accounts of anxiety and any associated help-seeking practices.

The work was undertaken in three phases: the first was a qualitative survey on anxiety experiences distributed to men and women; the second conducted interviews with men without a formal diagnosis of anxiety; the third phase consisted of interviews with men who did have a formal diagnosis of anxiety. We report here on phases two and three (NB The splitting of the latter two phases into diagnosed/not-diagnosed was not used to argue for necessary differences in how anxiety could be experienced or managed. Rather, it was used to aid the research process in terms of gaining access to participants and we recognise that we must not assume that experiences of anxiety are necessarily more severe for those with a diagnosis compared to those without). Before the study commenced recruitment and

TABLE 1 | : Participants.

Phase 2 (*N* = 10)	Phase 3 (*N* = 7)
P2.1 Malcolm 55 years old, white British and married with one adult child with cystic fibrosis. He has a high-powered managerial job in the banking industry	P3.1 Russell 38 years old, Asian British, single with no children. Diagnosed with PTSD, anxiety, depression, and hypersensitivity after a traumatic event in his teenage years. He has a part-time job and works with raising mental health awareness in his area
P2.2 Matthew 58 years old, Black British, heterosexual and divorced. He has two adult children and holds a managerial position in a governmental agency	P3.2 Frank 49 years old, white British, single with no children. He was diagnosed with social anxiety two weeks prior to his interview but acknowledged that anxiety has been a presence in his life since childhood. He has a full-time job as a chef
P2.3 Isaac 62 years old, white British, heterosexual and divorced. He has two stepchildren, one adopted child and was a foster carer to three more children. He is a semi-retired property developer-turned academic. He hopes to pursue a Ph.D. over the coming years in psychology	P3.3 Dylan 49 years old, white British/Irish divorced with one adult child. Diagnosed with acute anxiety and depression, he also has an extensive history of self-harm and substance abuse. He works full-time as an educator and campaigner for mental health issues
P2.4 Thomas 27 years old, white British, heterosexual and in a long-term relationship. He does not have children and is a freelancer in the arts and entertainment industry	P3.4 Ralph 54 years old, white British, unspecified marital status and no children. Diagnosed with anxiety, he works as a librarian. He has previously been a music blogger and now runs a mindfulness website
P2.5 Lincoln 27 years old, Asian British, heterosexual and single with no children. He is studying for his second masters, after completing his first one in gender studies. Currently spends his time split between West London and Oslo. He received a diagnosis of anxiety and depression in the months following his interview	P3.5 Patrick 44 years old, white British married with no children. Diagnosed with PTSD following a car crash. He has an extensive medical history in both physical and mental health spheres
P2.6 Fabien 67 years old, white British, heterosexual man and divorced. He has adult children and is a retired mental health nurse. Despite never receiving a diagnosis of anxiety, he has experienced acute anxiety at certain points of his life	P3.6 Christopher Late twenties, white British, in a long-term relationship with no children. Diagnosed with panic disorder and social anxiety. He has also received treatment for OCD and agoraphobia in the past. He works as a post-doctoral scientist
P2.7 Gareth 46 years old, white British, heterosexual and married with two children. He holds a high-level position in project management	P3.7 Leo 33 years old, white British, long-term partner and no children. Diagnosed with panic disorder (with a specific phobia of fainting in public). He works as a full-time firefighter and is active in social media conversations surrounding men's mental health
P2.8 Saleem in his thirties, Zimbabwean national, living in the United Kingdom. Heterosexual and married with one young child. He works as an engineer and has an active Muslim faith	
P2.9 Jack 39 years old, white British, heterosexual and married with two young children. He holds a managerial position at a bio-engineering firm in London and had recently been signed off work due to stress	
P2.10 Henry 25 years old, Welsh, heterosexual and single with no children. He recently graduated from his undergraduate degree in Liverpool and is an avid artist. He had experienced a phobia of water as a child	

data collection, ethical approval was obtained from (blinded for peer review) university ethics committee.

Sampling and Recruitment

The recruitment of men for phase two was facilitated through a question on the phase one survey asking if they would provisionally be willing to participate in an interview. The survey focused on everyday experiences of anxiety for men and women, and was advertised via the university, partner organisations and social media (N = 104; 56 women; 48 men). Ten participants were recruited to this study through this phase two process; none reported any current anxiety or mental health diagnosis. For phase 3, United Kingdom charities supporting people with anxiety were contacted, and a recruitment call was placed on Twitter. This recruitment call process was repeated on two further occasions. The criteria set down for phase three required that all participants were currently diagnosed with an anxiety disorder, with allowances made for comorbidities with other affective disorders, such as other anxiety disorders and depression. Note: we relied on self-report rather than medical records regarding diagnosis and did not specify candidate symptoms or duration of illness. The final number of participants recruited to phase three through this process was seven, with two reporting co-morbid depression, two citing co-morbid PTSD and one mentioning a former diagnosis for OCD.

For both phases reported here, potential participants were provided with an information sheet regarding the research project. To navigate any potential distress caused by the discussion of "sensitive topics", participants were informed that they were able to skip questions or withdraw from the interview altogether at any point. Contact information for anxiety helplines were also provided on the information sheet.

Brief biographical vignettes for the 17 participants ultimately recruited to phase two and phase three are provided in **Table 1**. To help ensure anonymity participants assigned themselves names (pseudonyms). Quotes used later in this paper include these self-assigned names but also include "P2" or "P3" in brackets to identify the phase that they were recruited to.

Data Collection

Once recruited, semi-structured interviews were conducted in 2017 with participants sequentially across the two phases. This is a well-established method which allows researchers to explore predetermined topics while also allowing the participants to expand upon their answers and experiences (Wahyuni, 2012). After setting participants at ease by asking them to say a little

about themselves, a broad opening question was asked: "Can you tell me about any experiences you've had with anxiety?" The topic guide subsequently included question areas around "doctors experiences", "medication" and "recognising anxiety". The majority of the face-to-face interviews were conducted at the university or at the participant's workplace depending on their preference.

It was anticipated that some participants (mainly in phase three) may not be able or willing to conduct the interviews in person and so Skype was offered as an alternative in both phases. Two of the phase two interviews and four of the phase three interviews were conducted via Skype. Interviews lasted 45–60 min in phase two and 60–120 min in phase three. Many of the phase three participants had been involved with varying levels of health care services, some over many years, and so appeared to be more comfortable with talking about their experiences with anxiety. The interviews in both phase two and three were recorded and transcribed by one of the authors and interview transcripts were returned to the participants to read over and make any amendments before moving forward into data analysis.

Biographical Note on Conducting the Interviews

Many of the participants appeared to expect a researcher in a white lab coat, with a clipboard and pen, ready to record their responses on a sheet of paper. As such, many appeared surprised to be greeted by a short, young lady with glasses too large for her face and without a clipboard or pen in sight. Despite a usually hesitant start, many of the participants relaxed significantly into the interview process after the first "springboard" question had been asked, and most interviews progressed with a conversational style. However, the two youngest participants in phase two appeared to remain uncomfortable throughout the interview process and required more input and prompting from the researcher-it should be noted that these interviews were conducted over Skype and so the lack of "in person" interaction may also have impacted how comfortable they felt throughout the interview process.

Analysis

As a method that can allow for both the summarisation of key features in a large body of data while also offering opportunities for thick descriptions of datasets (Braun and Clarke, 2006), thematic analysis was chosen. Thematic analysis places primacy on the active role that the researchers play in identifying patterns and in making decisions about which patterns best address the research aim. Importantly, it also allows for the identification of semantic (descriptive) and latent (hidden, implied) meaning within the data (Braun and Clarke, 2006). The six steps for thematic analysis, developed by Braun and Clarke (2006), was used as a guide throughout the analysis of the data, moving from data immersion and preliminary coding through to forming candidate themes and revising, refining and writing-up these themes. Initial coding and early categorising was undertaken by the lead researcher and amended in discussion with the team. Data collection continued, in both phases, until data saturation was reached and no new categories were being developed. While the numbers recruited to each of the two phases seem small, numerous studies have shown that the majority of themes (70–99%) are identified from the first six to ten interviews (Guest et al., 2020) and this was the case in this study. Further refinement of categories and development of themes was completed through research team discussions.

RESULTS

While the therapeutic discourse was invoked by our interviewees, this was complicated and constrained by neo-liberal and masculinity discourses privileging (male) resilience and responsibility and disavowing emotional talk. In the interviews, emotional communication and self-disclosure tended to be situated mostly within close romantic relationships, although in all-male contexts some (indirect) emotional talk was deemed possible. Analysis therefore generated two overarching themes: "Engendered anxiety disclosures with women", and "Calculations and covert communications with other men". These themes highlight not only how men are able and willing to engage in forms of emotional talk, but they also underline the importance of social relationships in supporting men to manage mental health issues.

Engendered Anxiety Disclosures With Women

Throughout the research, accompanying the perception that (other) men do not speak openly about their emotions, was the idea that women are more emotionally aware and open than men. Consequently, many of the participants highlighted a preference toward talking to female friends, family members or health professionals when dealing with anxiety:

> I actually find ladies have more empathy, more engaging. I'm gonna be quite honest with you, if you were a guy, I probably wouldn't have accepted your invitation (to be interviewed) so... I just couldn't open up as much as you know... if I was worrying and wanted to talk to someone, I would always go to a woman. (Patrick, P3)

Romantic partners, in particular, were singled out as especially adept at eliciting disclosure, as previous research has noted (e.g., Holmes, 2015; McQueen, 2017). Fabien (P2), who described himself as having a *"moderate anxiety complaint"*, mentioned that his anxiety levels notably diminished after he married. Similarly, Matthew (P3) stressed the efficacy of talking to romantic partners in helping to alleviate anxiety: "*When I was with my long-term partner, there you talk about everything because it was what you did"*.

Indeed, many of the participants explained that emotional talk had been positioned as a non-negotiable part of their close relationships. Saleem (P2) explained it in this way:

> I: Can you explain to me how you started to talk more about your emotions?
> S: Well (laughing) my mum used to shout at me for not talking like "can you please tell me what you're feeling" and then I think yeah... when I got married and my wife explained to me that, "listen, it's not a burden. Just explain your feelings and all the rest..." and that's when I started chatting.

In this sense, disclosures of anxiety are *engendered*–in part engineered by significant female others, including mothers (see also Wirback et al., 2018). Christopher (P3) also refers to his mother and female partner who were expressing concern about his reticence during a difficult period and their insistence on him opening up:

> I got very withdrawn again and my mum and my girlfriend got very worried, which is completely reasonable, but I do just tend to completely clam up... Just don't talk about it, internalise it. Um, they both let me know they were not happy with that arrangement so, I do try and talk about it more.

Clearly, for Christopher, emotional communication is an ongoing project with which he continues to struggle. Beyond the expectation that men will engage in emotional talk within romantic relationships, it appeared that the ability of female friends or family members to observe, perceive and enquire about a close male relative or partner's emotional well-being was similarly important. In reflecting on his emotional talking practices with a close female friend, Christopher noted:

> I, myself, have wondered why I am happy to speak to Diane I guess . . . I'm happy to answer the questions if people ask them. If people, ask me the right questions... for the most part anyway. If I'm having a really bad day, I just want to be left alone...

In outlining the importance of being asked the "right questions", Christopher's response demonstrates the centrality of relationships in encouraging (or constraining) types of emotional disclosure that men will use. It is also important to highlight that Christopher's willingness to speak to Diane is influenced by factors besides her gender. In exploring their friendship, he explained that she is both a clinical psychologist and personally suffers from anxiety. As a result, Christopher explained: *"she's just very open and forward-thinking in her attitude toward anxiety, as you'd hope for somebody in her position"*. As will be demonstrated later, establishing trust and shared ground can encourage more open forms of emotional talk in the presence of other men. The importance of being asked "the right questions" was similarly reported by Fabien:

> I have a partner who I have been with for three years... she does say "are you alright" and things like that from time to time. I think I went through a bit of a period last year when I was wrestling with all sorts of things, probably to do with the relationship-my future with her and so on which, I didn't particularly want to talk about. I suppose I could've been led into it if she'd have... got her own sort of talent, therapeutic talent and sort of dragged it out of me a bit more skilfully.

In asserting that he could have been "led into" an open discussion about emotions if it had been "dragged out" of him, Fabien highlights again the importance of relationships in helping to encourage emotional openness and the development of new anxiety management practices from someone initially reluctant to do so.

However, while the majority of participants noted that they would be more likely to view female partners, relatives and friends as more understanding of mental health issues, engaging in open emotional talk with women was not without its complications. Some participants also reported feeling frustrated when engaging in emotional topics with their partners or close relatives, as Malcolm (P2) highlighted:

> M: I think there's stuff that perhaps over the years we should've shared more deeply at an earlier stage...
> I: Do you know the reason why you haven't discussed them?
> M: Yeah... You know, it's going to be a half-hour conversation and there's something you want to watch on the telly in 10 min (laughing)... I was going to say you need to be precise in your language but, sometimes, you can be too precise in your language and you just need... (pause). Perhaps it's me but, it seems that quite a lot of what I say gets misunderstood (laughing)...

Feelings of being misunderstood within relationships, or lacking the vocabulary with which to adequately describe or relate to emotional conversations, were reported by six participants, reminding us that close relationships do not automatically generate therapeutic conversations. Johnson et al. (2012) use the phrase "guarded vulnerability" to convey how their male interviewees characterised self-disclosure to partners in the context of depression, and it seems apt in relation to anxiety here. So, the social webs surrounding individuals are complex, and in significant personal relationships the emotions of the "other" may impede the development of sensitive exchanges.

The notion that direct and open emotional conversations did not feel "natural", even when engaging with women (mothers, wives, female friends or female health professionals), was reported by other participants. After experiencing his breakdown, Jack highlighted the development of his talking practices with his wife:

> We do talk more about things and it feels a little bit forced almost . . . you know, because you sort of learn a technique . . . yeah we just talk more about things and it's just a bit more natural. It's probably a long way still to go but when you look back and think where I was then, it's quite different now.

In outlining the need to learn the "technique" of emotional talk, Jack's experiences are particularly interesting and link to Malcolm's previously noted feelings of frustration. Holmes (2015) similarly highlighted the need for men to "learn" how

to engage in verbal forms of support in distance relationships, with her participants reporting their initial attempts as difficult or cumbersome. Sometimes it is too difficult. Lincoln linked this issue to the dissolution of his relationship with his girlfriend, conceding that he has work to do to develop his emotional communication skills. Indeed, there are interventions which specifically target men who find emotional expression difficult, such as "alexihtymia reduction therapy"–alexithymia referring to an inability to recognise or describe emotions (Levant et al., 2009).

Calculations and Covert Communications With Other Men

Despite traditional understandings of homosocial interactions being policed and constrained by traditional masculinity norms (e.g., restricted emotionality; competitiveness; strength; e.g., Kimmel, 1994), with particular criticism reserved for men who try to talk about emotions (Felmlee et al., 2012), there is evidence that men can and do talk to each other about personal problems, albeit mostly indirectly (Lefkowich et al., 2017). However, this often requires complex negotiations around presentations of their male identity (Mackenzie et al., 2017). In this section, we identify the ways in which our participants navigate between such traditional expectations and more contemporary injunctions toward help-seeking and self-disclosure.

The notion that men do not openly talk about their emotions with other men echoed throughout the research. Nonetheless, the policing (or fear of being policed) of men's emotional expressivity within all-male settings did not necessarily stop the participants from (partly) engaging in emotional talk with their friends, and the forms that emotional talking took were heterogeneous. Even Dylan, who outlined struggling with opening up to men in the past, now regularly engages with other male service users in direct and open discussions about mental health and emotional wellbeing. Indeed, several participants drew attention to the ways that they may navigate their emotional engagements with friends:

> There's always a limit to what you talk about. There's never a full-blown conversation about feelings and emotions but there always is in some sort of form... you can speak openly more to some than others. (Henry, P2).

Henry's response highlights that there can be emotional communication between men, albeit limited, and that the extent of this may vary by relationship and context. With much of the literature stressing that men are more likely to engage in instrumental friendships (e.g., Robertson and Monaghan, 2012), it is easy to lose sight that men (and women) have many different types of friendships (see Frey et al., 2016).

Fabien (P2) neatly captures the calculations, potential risks and benefits of emotional talk with male friends:

> F: I think we all keep an eye on each other in a very covert way. We know each other well enough and if there's two of the three of us are in conversation and we mention the other, we'll say "well he's not so good at the moment" or "something's happening" or maybe... "is he ok?" ... You know, we'll go into that sort of territory, gossiping if you want but yeah... it's concern-concern for the other. But that's the way it happens for men, it's covert. It's in friendships or in a social context where um, you know, there's a pairing or a small group that are genuinely, long-term concerned friendships going on. I mean there's plenty of groups of men I'm sure who have been together for a long time you know, at various intervals of time and all they do is just get smashed out of their brain whenever they meet up, so I'm not saying it happens in all... But, in that type of friendship group where there's genuine concern, yeah I don't think you're not going to turn up one day and find that someone is blubbing with his head on the table and you've got to put your arm around him and say "there, there, what's happening" but, similar feelings could well be churning around inside him but, it's going to take a fair bit of skill (laughing) to try and extract something and get it sort of out in the open and getting it ventilated, talked about or whatever might be useful.

As we can see, with Fabien and his friends there is an ethic of care (*"keep an eye on each other"*; *"genuine concern"* etc.) notwithstanding the "covert" ways this may be conveyed and the "skill" that may be required to elicit disclosures. Clearly, it is important to stress the ability of peers to recognise when someone is in distress and to facilitate emotional talk. Sometimes participants distinguished between who and when they might open up, for example:

> If I was at university and dating, I would, you know, seek to speak to like my best friends first um, I would actively seek them out. However, if I was like walking back from a lecture with a friend... and it would just let slip. I haven't seeked them out but I'm with them now and I'm going to say it... you kind of keep it a bit vague rather than being like, with a best friend, you'd kind of like divulge "Oh I'm really into this girl" but with them, you'd go "oh yeah, you know, I've sort of been seeing ..." (laughing) and then you see what their reaction is and they're probably doing the same thing. They're probably a bit guarded. Thomas (P2)

So, engaging in emotional talk with "friends" can be potentially risky, and in remaining vague and potentially downplaying the emotional nature of the conversation, men may be able to navigate constraints on men's emotional talking practices. Moreover, in highlighting that he would *"see what their reaction is"*, the importance of the other in social encounters is reiterated. The role of other individuals in interpreting covert forms of communication and in encouraging and facilitating more direct conversational styles is particularly important here.

Some participants from phase 3 engaged with direct, emotional talking practices continuously with little regard for gendered "norms", while for other participants the use of open talking practices remained context-dependent. With a changing

climate toward mental health and well-being in the United Kingdom generally, especially with a growing recognition of mental health in the emergency services, Leo (a firefighter) has been able to establish a safe space at his work:

> Without trying to toot my own trumpet, I've been quite big and open about it. I've done videos that have gone round the brigade and written blogs and done all sorts of things um, that have sort of put me on the chopping block and actually the response has been pretty positive from a lot of people... we've had some pretty crap events... two people commit suicide in the last couple of years through mental ill-health, so it's almost been forced on us as something that this isn't something you can ignore, you know, there's serious consequences.

By reframing speaking out about his mental health issues as "quite big", Leo's has been able to "strategically negotiate hegemonic norms . . . to fashion a more "positive' masculine performance" (Lomas, 2013:178). This ability of men to re-negotiate traditional 'norms' into more positive forms of behaviour has similarly been documented in an array of social and health contexts (see De Visser et al., 2009; Sloan et al., 2009).

For Ralph (P3), who has gone through counseling and has used mindfulness to help him manage his anxiety, talking to others became important:

> There were a change in me... and I thought well, I know what I'm talking about yeah, you know, and I thought well, you know what's the worst that can happen... If you've got mental health issues, then you'll talk to your girlfriend about it where men won't. There's still that, that alpha male thing where you won't say. I mean, I didn't know until I got to the point I got to and I were talking to a couple of me mates and they'd been suffering from depression for years and they'd never mentioned it and I've never mentioned mine.

Ralph positions himself as an experiential expert and qualified to speak with authority on anxiety following his mental health journey and engagement with services. Again, the female partner is invoked as a safe harbour where feelings can be shared while other men are (again) construed as reticent. Taking the first step to talking openly in all-male social settings may be particularly daunting-a sentiment that was echoed by Dylan, who argued *"The hardest step for a man is the first time they talk about it and speaking out"*. However, it appears that taking the first step in an all-male setting can facilitate emotional engagements from other men. Dylan's experiences highlighted the power of "the first step", for his own confidence in emotional communication and in encouraging him to engage other men. Reflecting on how he initially began to work in mental health activism, Dylan recalled:

> I was invited to an event in the museum one night... came out me flat, pouring with rain, freezing cold wind but I thought "go on, make an effort and go along". Sitting at a table by myself with a glass of orange juice-I mean there's an achievement, glass of orange juice (laughing) and tap on the shoulder, I looked around all I could see was a pair of kneecaps. This guy is about 6 ft. 6. Introduced himself as Toby, a service-user lead... I told him about myself and what I'd been through, showed him me arms... and he was one of the first people in my life that had never judged us.

In presenting himself as a service-user and initiating a conversation about mental health, Toby was able to create a "safe space" for Dylan to talk about his struggles. He established shared ground and maintained a non-judgemental approach that was different from Dylan's past experiences with other men. Establishing shared ground between men may be particularly transformational in facilitating men's engagements with emotional talk. The approach that Toby took toward Dylan when they first met is one that Dylan now uses to approach other men who may need help:

> A guy came along here a few months ago. First, he wouldn't speak to us and I thought well I'll tell him about my background and my history and then he kind of trusted me a lot more... He's coming along to training and stuff as well and he said to me, had I been a psychiatrist or doctor, he would've just backed off.

Again, we can see the importance of establishing trust in encounters in which men are expected or required to engage in emotional topics or conversational styles. The establishment of trust in working with men in health contexts has been highlighted as particularly important in facilitating engagements with health professionals and in encouraging repeated engagements (Robertson et al., 2015). Establishing shared ground and trust within an all-male social group may be an effective way to encourage men to speak more directly and openly about their emotions and mental wellbeing. Research on men's use of online forums to discuss sensitive issues has also suggested trust as an important factor in men's delayed help-seeking in face-to-face contexts and as a facilitator of men's disclosure and discussion of a range of topics, from depression (Gough, 2016) and anxiety Drioli-Phillips et al. (2020a), Drioli-Phillips et al. (2020b), to body image and eating disorders (Flynn and Stana, 2012). Indeed, it appears that establishing trust or "safe spaces" may be vital in a range of contexts, both homosocial and otherwise, to encourage men to engage with emotional topics and to disclose any mental health and wellbeing concerns.

DISCUSSION

Our analysis highlights that men's anxiety-talk and help-seeking is embedded in (and often constrained by) interpersonal relationships and social interactions, and in wider discourses around masculinities. The impact that close romantic relationships can have on men's emotional talking practices was especially clear. The majority of the participants who were married or in long-term committed relationships understood emotional intimacy and expression to be a core tenet of a strong, sustainable relationship–notwithstanding some tensions and complexities at times. With male friends and acquaintances, participants reported being wary of self-disclosure and only volunteered information

indirectly, if at all, depending on the nature of the relationship/s and social context. Overall, the importance of trust and establishing shared ground between speakers was foregrounded. To echo Lomas (2013: 177), "restrictive emotionality is not inevitable in men … when men are given permission and safety to talk, they are well capable of insightfully analysing and sharing their emotions". What is clear is that men do talk, in a range of ways and for a variety of reasons. However, an often-overlooked aspect of men's emotional talking practices relates to the ability of others to recognise and encourage these practices. Thus, while the answer to the question "do men talk about their emotions?" is a resounding yes, one further, important, question remains: are we listening?

Despite the overwhelming emphasis placed on individualistic approaches to mental well-being and recovery, smaller bodies of research have highlighted that recovery in mental health terms is an "inherently social process" (Marino, 2015). Indeed, qualitative research highlights the crucial roles that family members, friends, professionals and an individual's broader community play in facilitating recovery from mental illness (e.g., Price-Robertson et al., 2017). While the key role of intimate partner relationships in facilitating men's emotional communication is well established, more research is required into the nature and form of men's emotional talking practices with other men, including (best) friends but also in the context of emerging community therapeutic groups for men (e.g., https://andysmanclub.co.uk/). Until now, researchers interested in male help-seeking, peer support and self-disclosure have largely been confined to online spaces such as discussion forums dedicated to health and wellbeing issues (e.g., male infertility; men and depression) where contributors are anonymous. Gaining access to offline, face-to-face meetings where men share stories of anxiety, depression and loss could provide additional valuable insights and recommendations for developing further, creative interventions tailored to specific groups of men.

Our analysis chimes with much of the qualitative research on depression which highlights the constraints associated with masculinity norms, the importance of partners and others in facilitating (partial) self-disclosure and help-seeking, and the (restricted) nature of emotional communication between men. Indeed, it must be emphasised that some of our sample are likely to have experienced co-morbid depression (two phase three participants explicitly mentioned a depression diagnosis), not to mention other mental health issues (two cited PTSD), so we must take care not to attribute our findings to anxiety-related issues exclusively. It is also worth drawing attention to the role of mental health literacy-those men who had been through counseling following an anxiety diagnosis were typically more inclined to self-disclose with others, male or female, most likely because of prior experience of doing so in formal contexts. Although men in general are thought to have limited knowledge and skills around emotional communication (see e.g., Ogrodniczuk et al., 2017), most of our participants referenced disclosing anxiety and related issues to others within relationships and contexts in which they felt safe and comfortable. It is clear, though, that many men require greater education and training in relation to mental health literacy (see Levant et al., 2009). In addition, research on men and anxiety is scarce and much more work is required to understand how men in different social positions, cultural locations and community settings communicate and manage their anxieties.

DATA AVAILABILITY STATEMENT

The datasets presented in this article are not readily available because not publically available. Requests to access the datasets should be directed to b.gough@leedsbeckett.ac.uk.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Local Research Ethics Committee, School of Health and Community Studies, Leeds Beckett University. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

BG-Lead for drafting and redrafting the paper and shaping the analysis. SR-Input to drafts HL-Data collection and initial analysis.

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Gender-Specific Differences in Depressive Behavior Among Forensic Psychiatric Patients

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Background: Women are almost twice as likely to develop depression than men, but men commit suicide more often. One explanation for this paradox is that current depression inventories do not fully capture typical male symptoms of depression. Several studies showed that most depression symptoms in men are masked by externalizing behaviors, such as aggressiveness, addiction, and risky behavior. Here, we explored the differences in depression symptoms between men and women in a forensic psychiatric sample.

Methods: We screened 182 forensic psychiatric patients and selected a matched sample (21 women and 21 men). External symptoms of depression were assessed with the Gender-Sensitive Depression Screening (GSDS) and internal symptoms with the Beck Depression Inventory Revision.

Results: Although externalizing behaviors were similar in both groups, we found a significant relationship between external and internal depression symptoms only in men. In addition, male forensic patients with a history of suicide had higher scores in the GSDS, whereas female patients with a history of suicide had higher scores in the Beck Depression Inventory Revision.

Discussion: The finding that the GSDS detected depression symptoms in men indicates that this instrument might be useful for developing assessments to prevent suicide in forensic practice.

Keywords: depressive symptoms, gender differences, suicide, forensic psychiatric patients, suicide attempt

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INTRODUCTION

Depressive disorders are among the most common mental disorders in Western society (Müters et al., 2013). Epidemiological studies show that the lifetime prevalence of depression is two to three times higher in women than in men (Angst et al., 2002; Busch et al., 2013; Boysen et al., 2014; Jacobi et al., 2014, 2016; Hasin et al., 2018). Paradoxically, the risk of suicide is consistently three times higher in men than in women [World Health Organization (WHO), 2019]. If one assumes that not all, but a large number of suicides are a direct consequence of a depressive disorder, one must

conclude that depression is underdiagnosed and undertreated in men (Wålinder and Rutz, 2001; Möller-Leimkühler et al., 2007; Möller-Leimkühler, 2010).

Studies have identified many reasons why rates of diagnosis and treatment are lower in men (Warren, 1983; Fava et al., 1991; Spence and Robbins, 1992; Courtenay, 2000; Möller-Leimkühler, 2000, 2002, 2016; Swendsen and Merikangas, 2000; Möller-Leimkühler et al., 2002; Zierau et al., 2002; Cochran and Rabinowitz, 2003; Yu et al., 2004; Berger et al., 2005; Brownhill et al., 2005; Kessler et al., 2005; Sigmon et al., 2005; Winkler et al., 2005; Emslie et al., 2006; Rutz and Rhimer, 2007; Davis et al., 2008; Hausmann et al., 2008; Magovcevic and Addis, 2008; Oliffe and Phillips, 2008; Chuick et al., 2009; Cohn et al., 2009, 2010; Levant et al., 2009, 2011, 2013; Rochlen et al., 2010; Weaver et al., 2010; Martin et al., 2011, 2013; McCusker and Galupo, 2011; Oliffe et al., 2011, 2012, 2013; Rice et al., 2013; Lai et al., 2015; Yousaf et al., 2015; Whittle et al., 2015; Seidler et al., 2016; Cavanagh et al., 2017; Reiß, 2017; Rommel et al., 2017; Braly et al., 2018; Keil et al., 2020; Serafini et al., 2016, 2017). For example, men use medical services and preventive and health-promoting measures far less often than women (Seidler et al., 2016; Rommel et al., 2017). This behavior is even more pronounced in men with mental disorders (Keil et al., 2020). In this context, research found that men's attitude toward seeking professional help depends on their conformity with masculine norms (Berger et al., 2005; Levant et al., 2009, 2011, 2013; McCusker and Galupo, 2011; Yousaf et al., 2015). The masculine role model implies competence, performance, and success. However, mental disorders, especially depression, are often accompanied by feelings of powerlessness, helplessness, and loss of control. These feelings are in contrast to masculine role expectations and can lead men to perceive depression as a failure in their role as a man (Warren, 1983; Courtenay, 2000; Emslie et al., 2006). To counteract this perception and protect their masculine identity against social discrimination, men often deny and distance themselves from depression or try to hide it from others (Sigmon et al., 2005; Hausmann et al., 2008; Möller-Leimkühler, 2016). As a consequence, they do not show prototypical symptoms of depression (e.g., sadness, crying, and hopelessness) to the outside world (Möller-Leimkühler, 2000, 2002).

Instead of seeking help, men often rely on self-medication with non-prescription substances, and their use of alcohol and drugs is particularly widespread (Möller-Leimkühler et al., 2002; Chuick et al., 2009; Rochlen et al., 2010; Oliffe et al., 2012, 2013; Reiß, 2017). This increased alcohol and substance use is reflected on the one hand by the high comorbidity between the disorders of depression and alcohol dependence (Swendsen and Merikangas, 2000; Kessler et al., 2005; Davis et al., 2008; Lai et al., 2015) and on the other hand by the finding that men with depression consume far more alcohol than women with depression (Angst et al., 2002; Martin et al., 2013; Cavanagh et al., 2017). Alcohol consumption often represents an escape from stressful situations, with the aim of suppressing and numbing the negative emotions (Chuick et al., 2009; Rochlen et al., 2010; Oliffe et al., 2011, 2012, 2013). Not only do men use alcohol and drugs to escape and avoid depression, but they also resort to other addictive behaviors. For example, men with depression show an increased focus and overcommitment in their professional lives, referred to as being a workaholic, particularly frequently (Spence and Robbins, 1992; Möller-Leimkühler, 2002; Cochran and Rabinowitz, 2003; Rutz and Rhimer, 2007; Oliffe and Phillips, 2008; Oliffe et al., 2013; Whittle et al., 2015). In numerous studies, men also report aggressiveness and outbursts of anger during a depressive episode (Fava et al., 1991; Zierau et al., 2002; Winkler et al., 2005; Magovcevic and Addis, 2008; Martin et al., 2013; Rice et al., 2013). In men, aggressive behavior is an accepted way to resolve conflicts and is seen as a practical way to regain control over negative feelings (Cohn et al., 2009, 2010; Weaver et al., 2010; Braly et al., 2018). Moreover, aggressiveness is firmly anchored in the masculine role model. Depressive men also show increased risky behavior (Brownhill et al., 2005; Martin et al., 2013; Cavanagh et al., 2017). For example, a study by Yu et al. (2004) observed dangerous driving behavior (fast driving, rapid acceleration, frequent lane changing, running red lights, and driving when tired) in men with depression or alcohol misuse.

The coping strategies listed above usually only help in the short-term, and over a longer period of time rather lead to an aggravation of the depressive symptoms and an intensification of stress. For many men, suicide is therefore the last option to cope with depression (Brownhill et al., 2005; Möller-Leimkühler, 2009; Armstrong et al., 2020). Suicide "appears to be the last resort to save self-worth and maintain the illusion of self-determination and autonomy of action — this only succeeds if the suicide attempt is violent and ends fatally" (Möller-Leimkühler, 2009) (authors' translation).

To sum up, studies show that in men the prototypical symptoms of depression are often masked by externalizing behaviors, such as alcohol consumption, aggressiveness, and risky behavior. However, these symptoms are not included in either the standard depression inventories or the diagnostic criteria for depression in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), making it difficult to diagnose depression in men. The symptoms listed in conventional depression inventories like the BDI-R cover somatic (e.g., "I have no appetite at all"), affective (e.g., "I cry at the slightest occasion"), and cognitive (e.g., "I can't concentrate anymore") domains. In particular, the affective domain tends to be sensitive to women, since they are predominantly based on symptom descriptions by women that reflect internalizing coping forms of depressive experiences, such as brooding, crying, depressive moods, apathy, or loss of drive and interest. However, these affective symptoms, which are considered prototypical, are consistently less frequently reported by men with depressive disorders, so that they often do not meet the threshold for clinical depression and thus fall off the diagnostic grid (Martin et al., 2011). To solve this problem, over the past two decades researchers in English-speaking countries have developed various gender-sensitive depression scales that are intended to capture these externalizing behaviors in depressed men (Zülke et al., 2018; Rice et al., 2020). The first German-language depression scale that includes both classic depression symptoms and patterns of externalizing behavior specific to men, the Gender-Sensitive Depression Screening (GSDS-25),

was recently developed by Möller-Leimkühler and Mühleck (2020). Externalizing symptoms, such as increased irritability, aggressiveness, outbursts of anger, hyperactivity, or addictive and risky behaviors, are not symptoms of a depressive disorder, since they serve men as a coping strategy to maintain the male role model. However, they can be used as indicators, in the sense of a clue, to diagnose depressive disorders in men. GSDSs capture a broader range of behaviors and should better identify depression risk in men.

In Germany, admission to a forensic psychiatric hospital follows a court decision according to Section 64 of the German criminal code. If a person has committed a serious offense as a result of a substance use disorder and has a high risk of reoffending and a favorable treatment prognosis, the court orders that the person be placed in a forensic psychiatric hospital. Therefore, we decided to study a forensic sample to examine whether externalizing behavior is associated with depressive symptoms in men or whether this association can also be observed in women. In other words, we wanted to investigate whether men and women with substance use show aggressive and risky behavior and whether they try to suppress the negative feelings associated with depression. Forensic psychiatric patients admitted for treatment according to Section 64 of the German criminal code are particularly suitable for investigating this question because they have been diagnosed with substance misuse and show behaviors such as aggressive and risky behavior much more frequently than people in the general population. A second reason for conducting this study in a forensic psychiatric sample is that suicide rates are extremely high in this population. The suicide rate in the general population in Germany is 19.7 per 100,000 men and 7.7 per 100,000 women [World Health Organization (WHO), 2019], but it is significantly higher in closed institutions: in prison, the suicide risk is 96.9 per 100,000 male inmates and 60.8 per 100,000 female inmates (Meischner-Al-Mousawi et al., 2020), and in forensic psychiatric hospitals it is 163.0 per 100,000 male patients (separate data for women are missing; Voulgaris et al., 2018).

Despite the extremely high suicide risk among forensic psychiatric patients, no studies have included forensic psychiatric samples to better understand the clinical usefulness of screening for externalizing symptoms in addition to completing standard depression inventories in this population. The use of GSDSs in forensic psychiatric patients might contribute to the development of more effective prevention measures and subsequently decrease suicide attempts in forensic psychiatric hospitals. Therefore, the aim of the present study was to explore differences in depression symptoms between men and women in a forensic psychiatric sample of people with substance misuse. We hypothesized that externalizing behaviors are correlated with depressive symptoms in men but not in women. Since depressed women generally score higher on the BDI-R than depressed men, the samples under study were parallelized with respect to the BDI-R score so that each woman was assigned a man with a similarly high score. As a result, the men studied did not differ from the women in terms of BDI-R score, even though they generally score less highly. When men report depression symptoms, they come into conflict with the prevailing masculine role model. One coping strategy to protect masculine identity is to report particularly masculine behaviors. Therefore, we expect that men who report depressive symptoms in the BDI-R should also score higher in the GSDS. A similar strategy is not expected for the female group, as the social role model allows women to be weak, tearful, or sad. If the addition of externalizing behavior better detects depression in men because a broader spectrum is queried, the GSDS should be more strongly related to suicidal behavior than the BDI-R. This is not expected for the group of women.

MATERIALS AND METHODS

Sample

A total of 182 forensic psychiatric patients aged from 19 to 79 years were asked to participate in the study [161 men and 21 women; mean (SD) age, 34.62 (11.24) years]. At the time of the survey, all participants were being treated in one of the 13 participating hospitals in the state of Bavaria, Germany. Inclusion criteria were age 18 years or older and ability to give informed consent in the opinion of the professionals responsible for their treatment. The exclusion criterion was the presence of acute symptoms of a psychotic disorder.

Procedure

Patients were informed about the study objectives and that neither participation nor non-participation would have any advantages or disadvantages with respect to their treatment. Patients who agreed to participate gave written informed consent. Patients received neither financial nor non-financial compensation for their participation. They completed the questionnaires in small groups in a separate room on the ward, and a research assistant was available to provide help. The study was funded by the Bavarian State Ministry of Family, Job and Social Affairs, Germany; it was approved by the Ethics Committee of the University of Ulm, Germany (application number: 174/17) and was performed in accordance with the Declaration of Helsinki.

Materials

In a first step, participants completed a questionnaire to collect sociodemographic (age, sex, and highest level of education), clinical (main diagnosis and prior suicide attempts), and legal data (index offense, i.e., the offense that led to the current admission). Then, they completed the GSDS (Zülke et al., 2018) and the Beck Depression Inventory Revision (BDI-II; Hautzinger et al., 2006).

The GSDS is a self-assessment tool that assesses depressive symptoms, especially those found more often in men (Möller-Leimkühler and Mühleck, 2020). The patients were asked about symptoms in the 6 months before admission to hospital. The questionnaire includes both typical and atypical, predominantly male (external) depressive symptoms. The 26 items of the screening are divided into six subscales: internal depressive symptoms (example: I had little interest or pleasure in my daily activities), stress perception (example: I felt under time pressure), emotional control (example: I kept my feelings to myself), aggressiveness (example: I had outbursts of anger that I could not control), alcohol misuse (example: I thought about alcohol more

often), and risky behavior (example: I endangered myself with my driving style). Each item is rated on a 4-point Likert scale ranging from *never* or *rarely* (= 0) to *mostly* or *always* (= 3). To evaluate the scores, we calculated the mean values of the subscales and the entire scale. The GSDS has proven good reliability (Cronbach's alpha of total scale, $r = 0.88$; Cronbach's alpha of subscales, from $r = 0.86$ to $r = 0.70$) and satisfactory convergent validity with the short version of the General Depression Scale (ADS-K, Spearman's Rho = 0.79; Hautzinger and Bailer, 1993).

The BDI-II (Hautzinger et al., 2006) measures the severity of depressive symptoms and is the most well-established inventory for depression. It measures the severity of depressive (somatic, affective, and cognitive) symptoms with the help of 21 items, each of which is answered by selecting 1 of 4 statements (example: 0 = I do not feel sad. 1 = I feel sad. 2 = I am sad all the time and I can't snap out of it. 3 = I am so sad or unhappy that I can't stand it). As described in the manual, we calculated a total score for all items (maximum: 63 points). The authors of the scale specify the following cut-off values: 0–8, no depression; 9–13, minimal depression; 14–19, mild depression; 10–18, moderate depression; and 29–63, severe depression [Beck et al., 1996; World Health Organization (WHO), 2017]. According to Hautzinger et al. (2006), the reliability is excellent, with values for Cronbach's alpha between $r = 0.89$ and $r = 0.93$ across different samples. The correlation between BDI-II scores and other depression questionnaires shows satisfactory convergent validity ($0.72 \leq r \leq 0.89$ and $0.68 \leq r \leq 0.70$).

Statistical Analyses

First, we assigned all 21 female patients to 21 of the 161 male patients by a case-control matching procedure, controlling for the factors age (±4 years) and BDI-II score (±3 total points). The matched sample thus comprised 42 patients (21 male and 21 female). Statistical analyses were performed on the matched sample. Sociodemographic data and questionnaire scores were analyzed separately for men and women. To compare the groups, we used paired *t*-tests for metric variables and Chi-squared tests or Fisher's exact tests for frequencies. Pearson correlations between the standard depression inventory (BDI-II) and the total mean value and the subscales of the GSDS were also computed separately for men and women. To compare the correlation coefficients in men and women, we tested them for significance according to the specifications of Eid et al. (2011)[1]. Finally, we compared the BDI-II and GSDS scores of patients with and without a history of suicide attempt by independent *t*-tests. Data were analyzed with IBM SPSS Statistics for Windows Version 25 (IBM Corp., Armonk, NY, United States).

RESULTS

We found no significant differences in sociodemographic variables between men and women (see **Table 1**).

Because the male and female samples were matched according to their BDI score, as expected we found no significant differences in the score between the two samples (see **Table 2**). In addition, the GSDS scores showed no significant differences between men and women in either the total mean score or the subscale scores, i.e., female forensic patients appeared to report exhibiting externalizing behaviors, such as aggressiveness and risky behavior, with the same frequency as men (**Table 2**).

However, the correlation analysis between BDI-II and GSDS showed gender-specific differences. In the male patients, the mean BDI-II score showed significant positive correlations with the GSDS total mean value and the scores on the GSDS subscales depressive symptoms, aggressiveness, emotional control, and alcohol consumption (see **Table 3**). In the female patients, the BDI-II score did not correlate significantly with either the total mean GSDS score or the subscale scores (see **Table 3**). Although women reported externalizing behaviors, such as aggressiveness, alcohol misuse, and risky behavior, with the same frequency as men, these behaviors were not associated with typical depressive symptoms (measured by the BDI-II). Comparing the Fisher-*z* transformed correlation coefficients of men with those of women validated the observed differences.

Finally, we examined whether the BDI-II and GSDS depression scores were different between patients with and without a history of suicide. As can be seen in **Table 4**, men with a history of attempted suicide had higher total mean GSDS scores than men without such a history. The groups did not differ in the BDI-II. In the women, the result was the opposite, i.e., female patients with a history of suicide attempt had higher scores in the BDI-II than women without such a history, but a past suicide attempt had no influence on the GSDS score.

DISCUSSION

The aim of this study was to explore internal and external symptoms of depression in a forensic psychiatric sample and to test the hypothesis that externalizing behaviors are correlated with depressive symptoms in men but not in women. The statistical analysis showed gender-specific differences between BDI-II and GSDS. In the male patients, the mean BDI-II score showed significant positive correlations with the GSDS score but in the female patients, the BDI-II score did not correlate significantly with the GSDS score. Our results confirmed previous investigations showing that dysfunctional coping strategies in depressed men are characterized by aggressiveness, alcohol use, and risky behavior (Möller-Leimkühler, 2005, 2009; Martin et al., 2013; Möller-Leimkühler and Mühleck, 2020). In contrast to male patients, female patients who exhibited external behaviors did not appear to have typical depressive symptoms because we found no significant correlations with the standard depression inventory BDI-II. Therefore, we suggest that in female forensic psychiatric patients aggressiveness, alcohol misuse, and risky behavior before admission to hospital might be related to other factors, such as certain criminogenic or social factors, but not to depression. The assumption that externalizing behavior *per se* is associated with depression could therefore be rejected.

[1] https://www.psychometrica.de/korrelation.html

TABLE 1 | Sociodemographic data of an age- and BDI-II score-matched sample of male (n = 21) and female (n = 21) forensic psychiatric inpatients.

	Men	Women	Statistics
	***M* (SD)/*n* (%)**	***M* (SD)/*n* (%)**	
Age	35.95 (10.6)	36.43 (10.0)	$t(20) = -0.872$, $p = 0.394$
Highest level of education			FET = 5.413, $p = 0.115$
None	3 (14%)	0	
Secondary school	11 (52%)	9 (43%)	
Technical school	6 (29%)	7 (33%)	
High school	1 (5%)	5 (24%)	
Main diagnosis			FET = 2.766, $p = 0.798$
Substance use disorder	13 (62%)	14 (67%)	
Schizophrenia	4 (19%)	3 (14%)	
Personality disorder	4 (19%)	2 (10%)	
Affective disorder	0	1 (5%)	
Other disorders	0	1 (5%)	
Index offense[1]			FET = 3.051, $p = 0.964$
Robbery	2 (10%)	1 (5%)	
Assault	8 (40%)	6 (30%)	
Sexual crime	1 (5%)	1 (5%)	
Fraud	1 (5%)	1 (5%)	
Theft	2 (10%)	1 (5%)	
Arson	1 (5%)	1 (5%)	
Drug offense/narcotic substances	4 (20%)	7 (35%)	
Other crimes	1 (5%)	2 (10%)	
Prior suicide attempts	6 (28%)	11 (52%)	$X^2(1) = 2.471$, $p = 0.208$

BDI-II, Beck Depression Inventory Revision; M, mean; SD, standard deviation; FET, Fisher's exact test.
[1]Missing data, men = 1, women = 1.

TABLE 2 | Descriptive statistics of the Beck Depression Inventory Revision (BDI-II) and Gender-Sensitive Depression Screening (GSDS) in an age- and BDI-II score-matched sample of male (n = 21) and female (n = 21) forensic psychiatric inpatients.

	Men	Women	Statistics
	***M* (SD) or *n* (%)**	***M* (SD) or *n* (%)**	
BDI-II depression severity (score)	13.71 (10.35)	15.00 (9.88)	$t(20) = -1.477$, $p = 0.155$, $d_{Cohen} = 0.322$
No depression (0–8)	8 (38%)	6 (29%)	FET = 0.913, $p = 0.967$, Cramer-V = 0.106
Minimal depression (9–13)	5 (24%)	6 (29%)	
Mild depression (14–19)	2 (10%)	2 (10%)	
Moderate depression (20–28)	5 (24%)	6 (29%)	
Severe depression (29–63)	1 (5%)	1 (5%)	
GSDS total mean value	1.06 (0.52)	1.26 (0.50)	$t(20) = -1.448$, $p = 0.163$, $d_{Cohen} = 0.316$
Internal depressive symptoms	0.93 (0.73)	1.33 (0.82)	$t(20) = -1.889$, $p = 0.073$, $d_{Cohen} = 0.412$
Aggressiveness	0.92 (0.89)	1.19 (1.12)	$t(20) = -1.095$, $p = 0.286$, $d_{Cohen} = 0.239$
Stress perception	1.08 (0.64)	1.36 (0.84)	$t(20) = -1.033$, $p = 0.314$, $d_{Cohen} = 0.225$
Emotional control	1.98 (0.70)	1.86 (0.94)	$t(20) = 0.525$, $p = 0.605$, $d_{Cohen} = -0.115$
Alcohol abuse	0.95 (1.00)	1.02 (1.06)	$t(20) = -0.197$, $p = 0.846$, $d_{Cohen} = 0.043$
Risky behavior	0.21 (0.68)	0.31 (0.73)	$t(20) = -0.409$, $p = 0.687$, $d_{Cohen} = 0.089$

FET, Fisher's exact test; M, mean; SD, standard deviation; BDI-II, Beck Depression Inventory Revision; GSDS, Gender-Sensitive Depression Screening.

A significant correlation is only evident in men, so we could hypothesize that the effect is due to masculinity. The lack of an association between external behaviors and the scores on the standard depression inventory in women indicates that the GSDS might not be suitable for detecting depressive symptoms in female forensic psychiatric patients.

We suppose, that men could be ashamed to report affective symptoms to others because they do not want to appear weak and helpless. Instead, they could exhibit particularly masculine behaviors (drinking alcohol or being aggressive) that fit the male role norm. Thus, externalizing behaviors in men primarily serve masking or coping purposes. In the context of psychiatric diagnosis, externalizing behaviors could be used as additional indicators of a depressive disorder. However, externalizing behaviors are not *per se* indicators of a depressive disorder in men; they occur when men want to conform to the male role mode. In addition, the presence of related psychiatric disorders such as substance use disorder or dissocial personality disorder must be considered as a possible cause of the externalizing behaviors.

Several studies have established impulsivity, substance misuse, and aggressiveness as significant risk factors for suicidal behavior (Hillbrand, 1995; Mann et al., 1999; Stålenheim, 2001; Dudeck et al., 2016; Armstrong et al., 2020; Shafiee-Kandjani et al., 2020). Our data in male patients corroborate these findings because GSDS scores (but not standard depression inventories) were associated with previous suicidal behavior in men; thus, the early detection of external depression symptoms could contribute to establishing a precise prognosis and preventing suicidal attempts. Given the increased risk of suicidal behavior in forensic psychiatric patients, establishing preventive measurements is a high priority. The GSDS is a good instrument for identifying

TABLE 3 | Pearson correlations between the Beck Depression Inventory Revision (BDI-II) and Gender-Sensitive Depression Screening (GSDS) total score and subscales in an age- and BDI-II score-matched sample of male (n = 21) and female (n = 21) forensic psychiatric inpatients.

	BDI-II score		
	Men	Women	Significance test for correlations
GSDS total mean value	0.691**	0.278	z = 1.693, p = 0.045
Depressive symptoms	0.731**	0.070	z = 2.582, p = 0.005
Aggressiveness	0.638**	0.243	z = 1.521, p = 0.064
Stress perception	0.143	0.367	z = −0.723, p = 0.235
Emotional control	0.469*	0.343	z = 0.454, p = 0.325
Alcohol consumption	0.492**	−0.289	z = 2.509, p = 0.006
Risk behavior	0.339	−0.076	z = 1.287, p = 0.099

Significance tests for correlations were performed according to Eid et al. (2011). BDI-II, Beck Depression Inventory Revision; GSDS, Gender-Sensitive Depression Screening.
*$p < 0.05$, **$p < 0.01$.*

TABLE 4 | Comparison of patients with and without a history of suicide attempt in an age- and BDI-II score-matched sample of male (n = 21) and female (n = 21) forensic psychiatric inpatients.

	Suicide attempt	No suicide attempt	
	n or *M* (SD)	*n* or *M* (SD)	Statistics
Men	6	15	
BDI-II score	15.80 (9.04)	14.27 (10.98)	$t(19) = 0.346$, $p = 0.733$, $d_{Cohen} = 0.151$
GSDS total mean value	1.52 (0.45)	1.04 (0.45)	$t(19) = 2.440$, $p = 0.025$, $d_{Cohen} = 1.066$
Women	11	10	
BDI-II score	20.83 (11.84)	10.87 (8.53)	$t(19) = 2.169$, $p = 0.043$, $d_{Cohen} = 1.048$
GSDS total mean value	1.18 (0.56)	1.02 (0.52)	$t(19) = 0.642$, $p = 0.528$, $d_{Cohen} = 0.310$

M, mean; SD, standard deviation; BDI-II, Beck Depression Inventory Revision; GSDS, Gender-Sensitive Depression Screening.

atypical external symptoms of depression in male forensic psychiatric patients and might be suitable for use as a standard evaluation instrument in forensic psychiatric settings. On admission to forensic psychiatry, the main focus of diagnostic assessment is to identify a substance use disorder, as this forms the basis of treatment. A depressive disorder as a secondary diagnosis is assigned extremely rarely (in the present sample, only one woman received this diagnosis). Nevertheless, 11 of 42 patients reported symptoms of moderate depression and two reported symptoms of major depression in the BDI-R. If the substance use disorder is merely a consequence of an underlying depressive disorder, the depression would have to be treated first and the addictive disorder only in a second step. In other words, doctors and therapists in forensic psychiatric hospitals should check for the presence of a depressive disorder – also in view of the high suicide risk of their patients – and take into account that men tend to mask their feelings. The present study illustrates the urgency of considering external behaviors when diagnosing depressive symptoms in men and of identifying further gender-specific risk factors for depression in forensic psychiatric populations. In addition to the use of suitable gender-sensitive depression scales, programs should also be developed to draw attention to male depression. For example, medical staff should be sensitized to these symptoms so that they can easily identify depression in men. Patients should also be informed about atypical symptoms of depression so that they can recognize these symptoms and seek professional support.

Limitations

The results of the present study are based on 42 patient data and should be interpreted with caution. Replication of the study on a larger sample would be desirable. One further limitation of the present study is that we did not assess masculinity beliefs. In addition, self-reported data can result in various biases; for example, patients may give socially desirable responses. Although none of the participants received antidepressants during the study, the fact that we did not consider differences in medication (and side effects) can be seen as another limitation. Given that most of the forensic psychiatric patients in Germany are male, few female patients were available for this study, resulting in a small sample size. Another limitation is that there was no assessment of anti-social attitudes and other key criminogenic factors.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Ethics Committee of the University of Ulm, Germany. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

MD, IF, and A-MM-L designed the study. MB collected the data. ER and JS analyzed and interpreted the data and wrote the initial draft of the manuscript. All authors had full access to all the data in the study and take responsibility for the integrity and accuracy of the data analysis. All authors contributed to, read and approved the final version of the manuscript.

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Men's Help-Seeking for Distress: Navigating Varied Pathways and Practices

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There is a widely accepted dominant narrative surrounding men's mental health help-seeking, that men are less likely to pursue formal mental health support on account of hegemonic masculine ideals that limit emotional expression and vulnerability. Across the literature, little attention has been given to the varied ways in which men can and will seek out help when experiencing mental health troubles. This paper reports findings from a qualitative study of men's experiences of distress, specifically focused on their help-seeking and everyday coping and management of distress. Between 2016 and 2017, 38 individual interviews were carried out in South Wales, United Kingdom, with men of a range of ages (21–74 years of age) and social backgrounds. Analysis identifies nuanced help-seeking practices and pathways, emphasizing ways in which men can and will engage with mental health support. Some men struggled with articulating personal issues in mental health terms, and some portrayed ambivalence to help-seeking, yet at the same time reconstructed help-seeking to positively align with masculine values. The paper further highlights the significant influence of familial and friendship networks in the help-seeking process as well as the value of therapy for men experiencing mental health difficulties, challenging the idea that masculinity inhibits the disclosure of emotional problems. Awareness of the diversity of ways in which men can actively engage with their mental health is needed so that mental health support interventions and practitioners can best reach out to men experiencing distress and provide gender-sensitive support suitable to a range of different men.

Keywords: men's help-seeking, distress, men's mental health, masculinities, wellbeing

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INTRODUCTION

In recent years, the subject of men's mental health has started to receive more academic attention. According to the Adult Psychiatric Morbidity Study (2014), women are still more likely to experience a common mental disorder (different types of depression and anxiety) than men, with one in five women self-reporting common mental disorder symptoms, compared to one in eight men (McManus et al., 2016). Yet, it is arguable that such data does not reveal the true extent of male mental health difficulties. Brownhill et al. (2005) argue that distress can manifest differently in men and as a result their expression of emotional difficulties can differ to women's. Over the years, evidence has suggested that men are less likely to seek help or treatment from a professional for mental health difficulties on account of perceived threat to masculine norms (Courtenay, 2000; Moller-Leimkuhler, 2002; Addis and Mahalik, 2003; Galdas et al., 2005; O'Brien et al., 2005). As a result, large statistical datasets that explore prevalence of disorders and gender differences may not

reflect the true level, or experience, of common mental health difficulties in men. For example, in 2019, men in the United Kingdom continue to be three times more likely to take their own lives than women (Office for National Statistics (ONS), 2020). This points to the complexity of men's experiences of distress that belie the oversimplification of men's behavior measured by prevalence rates. An understanding of men's own lived experiences of mental distress, and the extent to which gender norms still impact men's help-seeking behaviors have become an increasingly important topic of sociological interest. This is needed to be able move forward in engaging men in their mental health management and support those who might be particularly vulnerable to suicide.

Some authors maintain that much previous research on men's mental health has occupied the "men as deficient" narrative and focusing on what men do not do in relation to their health and illness (Kiselica and Englar-Carlson, 2010; Seidler et al., 2016) rather than examining how men might be willing and able to engage in their own mental health and wellbeing. The research discussed in this paper aims to provide a nuanced understanding on how men engage in help-seeking for distress, rather than examine why men do or do not pursue support. In doing so, it adds to existing evidence about the relationship between masculinity and mental health help-seeking. The main aim of this paper is to examine how a diverse sample of men navigate help-seeking for broad mental health difficulties in everyday life and considers how masculinities can be practiced both negatively and positively to both restrict and facilitate mental health help-seeking.

MASCULINITY AND DISTRESS

The social construction of gender can be understood as one of the most important sociocultural factors associated with, and influencing, men's health related behavior (Courtenay, 2000). Through Connell (1995; 2005) social constructionist masculinities framework, gender is considered a configuration of practice through which social life is organized (p.71). Masculinity, or the now preferred term of masculinities, depicts the normative ways of being a man that can be constructed and enacted in various contexts of everyday social life (Connell, 1995). The notion of hegemonic masculinity has traditionally been referred to as the most culturally "honored way of being a man, that requires all other men to position themselves in relation to it: (Connell and Messerschmidt, 2005; 832). Yet, men in general may struggle to live up to the prescribed set hegemonic ideals (Courtenay, 2000; Moller-Leimkuhler, 2002; Chandler, 2012). Following this, multiple masculinities then emerge and compete. Thus, different kinds of masculinities that are vastly diverse, changing, differentiated and dynamic are present in all aspects of life. Robertson (2007) suggests that understanding masculinities as hierarchical "configurations of practice" that men move within and between provides a framework for exploring how and why men "do" health differently in differing social contexts (Robertson, 2007: 35). Over the past 2 decades, there has been an increase in qualitative research that explores men's ill-health experiences, specifically how masculinity facilitates and inhibits behaviors and practices in health contexts (Robertson, 2007: 21). Courtenay (2000, 2003) influential work on masculinity and men's health adapted Connell (1995) masculinities framework and demonstrated how by dismissing health care needs and health promoting behaviors such as asking for help and avoiding unnecessary risk, men are in fact constructing a particular form of dominant masculinity.

Constructs of masculinity can contribute to manifestation of distress in men. A study by Oliffe et al. (2010) found that the ways in which men embody depression in their everyday lives, for example through anger, isolation and risk-taking, can lead to symptoms of depression being interpreted as expressions of masculine ideals instead (Oliffe et al., 2010). Brownhill et al. (2005) "big build" model explained how masculine practices relating to depression, including avoidance, numbing, risk-taking and aggressive behaviors, could result in a path of destructive behaviors and further emotional distress. A study by Emslie et al. (2006) noted that during recovery from depression, it was important for participants to reconstruct a valued sense of themselves and their own masculinity (Emslie et al., 2006). Values associated with hegemonic masculinity (such as re-establishing control, being "one of the boys" and having a responsibility to others) were frequently incorporated into the men's narratives of depression. Yet, they also found alternative patterns of expression, such as creativity, that challenged dominant forms of masculinity. Similarly, Valkonen and Hanninen (2012) found that masculine ways of thinking, and acting were also used as a way to facilitate coping with mental distress.

Men, Masculinity and Help-Seeking

Health behaviors such as seeking out support have been seen to contribute to reinforce the active construction of gendered identities. By resisting support seeking it has been said that men are attempting to preserve manly self-reliance, control and autonomy and avoid appearing weak and vulnerable, practices of "hegemonic masculinity" (Connell, 2005). According to Addis and Mahalik (2003), men are less likely to seek help for a problem they see as unusual (e.g., mental health difficulties) and when they see it as a central part of their identity, for example, having emotional control is perceived as an element of masculine identity. Similarly, O'Brien et al. (2005) found that men who were most vulnerable were those with emotional or mental health problems, which they often interpreted as "stress" rather than admit to the "unmanly" diagnosis of depression (O'Brien et al., 2005: 515). Despite widespread reluctance to seek help amongst their participants, there were also instances where some men (e.g., firefighters) sought help as a way to preserve masculinity (because their jobs depended on sustaining good health and wellbeing) rather than dismantle it. Maintaining masculine practices can also be used in positive ways in relation to men's help-seeking, and this should be considered when researching men's help-seeking. Likewise, Farrimond (2012) argued hegemonic masculinity should be viewed with greater flexibility in relation to men's health help-seeking

practices, as her participants reformulated dominant masculinities in their accounts of help-seeking. Men in her sample negotiated masculine identities according to who was present (e.g., friends in similar situations, work colleagues), the type of illness and the identity demands of the social context. Farrimond (2012) argued that "taking action" (i.e., help-seeking) in relation to help-seeking was being reformed as a self-efficient, masculine act. However, Farrimond (2012) study focused on middle-class professional men who may have had better access to social tools that allowed them to reconstruct masculine values in this way. How help-seeking might be reformed or enacted for different men at different times warrants further attention.

The above studies examined help-seeking more generally, and there has since been much empirical research that has explore mental health, specifically seeking help for depression. Sierra et al. (2014) review reinforced the view that masculine attitudes and expectations of being strong and in control can increase men's vulnerability to depression through perceptions of potential impacts to men's masculinity, for example, in the case of help-seeking (Sierra Hernandez et al., 2014). However, like other studies (O'Brien et al., 2005; Emslie et al., 2006; Farrimond, 2012), when Sierra Hernandez et al. (2014) participants did seek treatment for depression, they redefined their masculine identity and perceived their help-seeking as retaining control, being responsible and actively dealing with their issues. Johnson et al. (2012) found that the gendered construction of help-seeking discourses took the shape of five discursive frames, with four of these discursive frames being variations on the dominant social discourse of men's help-seeking and masculinity (i.e., men are often resistant to seeking help on the basis of masculine ideals) and one, genuine connection, reflects men's willingness to talk openly about depression and how masculinity can be used in alternative ways to manage depression. Similarly, Siedler and colleagues' (2016) systematic review found that conformity to traditional masculine gender norms impact on men's attitudes, intentions and behaviors related to help-seeking yet they established that men would seek help if it were accessible and appropriately engaging for them. What would add to these important studies is a broader understanding on the help-seeking process and ways in which different men seek out both formal and informal support.

Such qualitative studies have been influential in discerning men's gendered experiences of mental health troubles and how constructions of masculinity can influence help-seeking behaviors. Many have argued that much of the work examining men's help-seeking experiences are somewhat limited because their sample populations mostly consist of single, heterosexual, white, employed, and well-educated men, who had already sought help for their depression and are willing to talk about their experiences to a researcher. Qualitative studies concerning help-seeking and men may miss out the experiences of socially diverse men, for example men of different socioeconomic status, sexuality and ethnicity, as well as the "silent" men who have experienced distress and emotional troubles and not sought out support. Furthermore, the tendency to focus on depression has tended to dominate the literature on men's mental health and it would be beneficial to examine non-clinical samples of men who have experienced distress but may or may not have received a formal diagnosis.

Defining Help-Seeking

Rickwood et al. (2005) describe help-seeking in response to mental health difficulties as "the behaviors of actively seeking help from other people. It is about communicating with other people to obtain help in terms of advice, information, treatment and general support in response to a problem or distressing experience" (Rickwood et al., 2005: 4). This paper makes use of Rickwood et al. 's., definition of help-seeking through exploring the processes and various pathways in which men may go about seeking out support for emotional difficulties and troubles in living. Diverse sources of help include informal help-seeking from personal social relationships and networks such as family and friends, and formal help-seeking from professional sources of help such as mental health and health professionals.

Diversity in the behaviors of different men across various mental health difficulties, context and time require recognition. Help-seeking should be viewed as an interactive, ongoing process of formal and informal support seeking (Wenger, 2011: 495). In this respect, this paper considers help-seeking in a more nuanced way that acknowledges the process of help-seeking as being influenced by perceptions, interactions, skills and strategies, and changeable approaches and outcomes.

Findings presented in this paper are from a doctoral study of men's experiences of help-seeking and everyday coping and management of mental distress (2015–2019). The overarching aim of this paper is to examine how the help-seeking process might look for different men, with the research question asking: what are men's experiences of engaging in help-seeking for distress?

MATERIALS AND METHODS

Using a cross-sectional, qualitative design 38 men were interviewed, recruited from both the general population and mental health support groups. The study was given ethical approval from The School of Social of Sciences' research ethics committee at Cardiff University.

Recruitment

Between 2016 and 2017, 38 men in South Wales, United Kingdom (UK) were recruited through purposive sampling, seeking out men from both the general public and specifically men who attended support groups for mental distress. The reason for two sample groups was that the study aimed to examine both formal help-seeking (such as use of support groups and mental health services) as well as the more informal routes of help-seeking and everyday coping mechanisms. In addition, the purpose of recruiting men from the general public was to seek diversity within the sample by age (range 21–74 years) and socio-economic status. Men who self-identified as having experienced distress were recruited because the research was interested in including men with and without a formal diagnosis of a mental health problem. This was so that the research could elicit a

TABLE 1 | Sample groups and participants.

General public participants *n* = *19* age range: 25–74	Support group participants *n* = *19* age range: 21–74	Occupational category (NSSEC three class version measurement)
John (41), Simon (42), Oliver (36), George (45), Jake (29), Daniel (34), Harry (65)	Thomas (62)	1. Higher managerial, administrative and professional occupations
Dave (27), Nick (56), Shaun (48), Colin (retired, 74), Nathan (49), Kevin (retired, 65)	Kyle (34), Richard (24), Peter (retired, 62), Joseph (retired, 68), Andrew (retired, 68), Mark (retired, 64), Jim (retired, 74), James (retired, 61), Rhys (57), Samuel (29), Patrick (54)	2. Intermediate occupations
Geoff (54), Jason (55)	Albert (51), Ben (52)	3. Routine and manual occupations
Adrian (59), Steven (52), Joel (33)	Barry (38), William (44), Matthew (54), Adam (48)	[a]Never worked and long term unemployed
Mike (25)	Rick (21)	[a]Student

[a]*Residual operational categories: When using the three-class version "Never worked and long-term unemployed" and "Student" are not classified within a category.*

broader understanding of help-seeking in men's everyday lives. The paper will discuss mental health and distress as broadly defined. Defining "mental health" can be controversial as well as problematic because there are markedly different ways of speaking about mental normality and abnormality in today's society (Rogers and Pilgrim, 2010). The author acknowledges that there are many different terms used today, for example, "mental health," "mental ill-health," "mental well-being," "mental health problems," "mental distress" and "emotional difficulties." The author uses the term distress and emotional difficulties, defining it as a challenging emotional experience (e.g., anxiety, low moods, stress, isolation). According to Holland and Blutz (2007) distress can happen in a range of severities, which may not lead to a clinical diagnosis of mental health problems. Men with severe mental illness (such as schizophrenia) were excluded from the study as the focus was on common mental health difficulties such as depression, anxiety, and non-clinical emotional distress. Also, those under a current psychiatric care plan or at any perceived risk were not included in the study.

Two different recruitment fliers (for men using support groups and men from the general public) were created and distributed, briefly describing the study and inviting men to contact the researcher to take part. To access men who had attended support groups, facilitators of third sector and voluntarily attended support groups acted as gatekeepers and were contacted first with the recruitment flier, asking if the researcher could initially attend a group to talk about the study. Following this, men from support groups who were interested in taking part were able to speak to the researcher and subsequently arrange an interview. To recruit men from the general population, the researcher distributed fliers in various public locations and institutions, specifically institutions perceived to be those where men frequented, such as pubs, bars, betting shops, barbers, sports clubs and some workplaces. The researcher approached men with the researcher flier inviting them to take part in the study and in most instances the researcher obtained contact details and interview arrangements at that initial time of speaking. Snowballing also took place through participants already recruited.

Table 1 shows the sample of participants, with their ages and classified socio-economic status, using the three-class version of the National Statistics Socio-economic classification (NS-SEC measurement). Despite the recruitment aims and efforts, most participants were White British, with two participants being non-White. This is a limitation of the study, mostly likely due to the population demographics of South Wales, where the recruitment took place, despite attempting to access inner-City locations that might be more diverse in terms of ethnicity. Two men in the general population sample identified as gay. Information about participants' mental health status was not officially collected using a written questionnaire but the focus of the interview schedule included questions asking participants to recall their experiences of mental health difficulties. The researcher endeavored to ensure participants felt comfortable retelling their experiences of distress during the interview, keeping it relaxed and conversational to create a comfortable space for men to share their experiences. Similarly, general health status was not formally collected but questions around general health and any experiences of broader health issues were asked during the interview. Pseudonyms were assigned at the interview stage to protect participants' anonymity.

The author, and sole researcher, carried out individual in-depth, semi-structured interviews at a time and public location convenient to the participant, which included a university room, various coffee shops and local pubs. While there were some ethical concerns with conducting interviews involving sensitive content in public places, researcher safety was of a particular concern as interviewing men in their own home can be potentially dangerous for a lone female researcher. To overcome this, the researcher offered participants the choice of public space that they felt comfortable with for the interview to be held. Written informed consent was gained prior to the interview with ongoing consent sought verbally throughout the interview. An interview topic guide was used, which differed slightly for the two different sample groups of men and included "ice breaker" questions about themselves and their lives, questions on any experiences of distress and emotional difficulties, questions on help-seeking, questions about everyday informal coping mechanisms when experiencing distress, and specifically for the men who had accessed voluntary groups, questions about their use of support groups for distress. At the end of the interview all participants received a resource sheet of mental health services, and the researcher had a safeguarding protocol in place for terminating the interview should any participants have

become distressed during the interview. On occasion, when some participants became visibly upset, the researcher paused the interview and asked if they wanted to take a break or finish the interview.

Data Analysis

The interviews were digitally recorded and transcribed verbatim by the author, which assisted the researcher to become fully emersed in the data. Thematic analysis was used since it lends theoretical freedom and flexibility (Braun and Clarke, 2006). The researcher coded the transcripts using NVivo version 10.2, taking both an inductive and deductive approach (Strauss and Corbin, 1990). This involved having a coding list of predefined, deductive codes based on constructionist masculinities theory (e.g., traditional beliefs, masculine language) and literature on men's mental health and help-seeking (e.g., barriers to help-seeking), supplemented with codes that arose inductively. Following repeated reading of the interview transcripts, initial themes and codes were derived and the researcher began coding broadly on the general population sample dataset first. Some data segments had several different codes assigned to them and codes were then combined to create themes. Themes can be identified by, "bringing together components or fragments of ideas or experiences, which are often meaningless when viewed alone" (Leininger, 1985: 60). Data was compared within and across the interviews from both sample groups and continued to allocate descriptive codes to data segments. Initial themes and thematic maps were then reviewed and refined to include the merging of the two sample groups.

Theme definitions were produced and validated by returning to check on the coded data and re-read extracts. The aim was to interpret the meanings and significance underpinning each theme and move from a descriptive to an interpretative level. To do this, the researcher used Connell (1995) social constructionist framework of masculinities to interpret participants' mental health seeking practices in relation to masculinity as well as applying new literature relating to emerging themes. Ways in which participants drew upon, and moved within and between, different patterns of masculinities when articulating their experiences were interpreted using the constructionist gender framework and incorporated into the examination of men's nuanced help-seeking practices more broadly. Data analysis was carried out solely by the author with support of two research supervisors who reviewed some coding frames, thematic maps and theme descriptions with data extracts and chapter drafts to ensure rigor and reliability of the analysis.

RESULTS

A total of 38 men aged 21–74 years participated in the study. In contradiction to the idea that men do not seek help, most participants from the general population sample had also sought, or at least attempted to seek out, some type of formal support for mental health and emotional difficulties. Analysis revealed that participants' help-seeking practices were not straightforward, and their navigation of help-seeking routes and types of treatments were complex and varied, depending on individual circumstances. Nevertheless, there were six broad themes identified across the accounts regarding practices of help-seeking: 1. Using other terms to articulate distress; 2. Ambivalence around help-seeking; 3. The importance of significant others; 4. Influential cultural milieu; 5. Reframing help-seeking, and 6. The benefits of talking to others. These themes focus on a more nuanced understanding of ways in which men speak about mental health help-seeking.

There were broad themes identified across the accounts from all participants around their varying practices of help-seeking. There were not clear distinctions in help-seeking practices between the two different sample groups and support group attendance often came after speaking to the GP or attempting to seek out talking therapies. For this paper the focus will be on initial help-seeking behavior and the nuanced ways in which men speak about help-seeking practices and pathways are examined within these themes.

Using Other Terms to Articulate Distress

Some participants spoke of interpreting, and articulating, symptoms of distress (such as fatigue, low mood, restlessness and irritability) as something other than mental health difficulties, which impeded seeking out professional help. Oliver spoke of his experience when he was at University in his early 20's and appeared to interpret his emotional difficulties as a physical issue:

> Interviewer: Did you go to the GP off your own back?
> Oliver: Yeah, it was just, it was sort of an on-going [thing] because I was becoming, I wasn't really sleeping well. I was very, very restless and anxious all the time and I perceived it as some kind of physical problem and my GP was like no I don't think so (Oliver, 30–34 years. General public sample).

As a result of this difficulty interpreting distress symptoms, participants were reluctant to articulate personal issues as mental health difficulties, which could be a way of protecting their masculine selves. Oliver's experience aligns with traditional beliefs that for men, physical illness represents a legitimate reason for accessing health services whereas struggling with aspects of daily living might not warrant professional help due to the stigma still attached to it. Articulating distress using different terms to a General Practitioner (GP) revealed symptoms that generated discussion of the less preferred topic of "depression." Similarly, Nick had previously experienced cancer and as a result was out of work for some time (although was working at the time of interview). The researcher asked about how that time affected him emotionally and he described a previous time consulting the GP for "something different" but leaving the appointment with anti-depressants, having been told that he was experiencing depression:

> Interviewer: Did you go to the doctors about depression when you were feeling low or during those times?

> Nick: No, no. I was probably more depressed when I split up with my son's mother, which was years before then. I did see a doctor then, not about it, he just knew.
> Interviewer: Were you going for some other reason?
> Nick: Yeah, I can't remember. He was a locum; he wasn't a regular. He was just there for like a fortnight and he said, "I think you're depressed" and he said, "are you?" And I told him, and he gave me some tablets (Nick, 56–60 years. General public sample).

When Nick was asked how he had replied to the GP after being asked if he thought he was depressed, he said "Yeah, I did say yeah. I can't remember why I went there. I think I was like low and like tired all the time and everything like that and he said he sort of just knew. He's the only one that's ever said it to me" (Nick, 56–60 years).

Nick's reluctance to articulate his personal issues as mental health difficulties points to how dominant discourses around men's mental health are still very much present. Hegemonic practices that limit emotional expression shaped the initial help-seeking process for these participants as they attempted to avoid vulnerability by using alternative ways to articulate experiences of distress. In minimizing the severity of their distress experience and the magnitude of need for help, the men could protect masculine identity and any potential for loss of self-esteem in being given a psychiatric classification (Johnson et al., 2012: 352). Nevertheless, by initially presenting to the GP (albeit not explicitly for emotional distress) these participants recognized that something was wrong and acknowledged the need for some assistance. This points to the counteracting of hegemonic standards that have traditionally inhibited men from seeking professional help, pointing to the ways in which different men, dependent on context, can engage in various behaviors typically associated with different masculine ideologies.

In connection to using other terms to articulate distress, two participants explicitly noted how in discussion of mental health and support seeking, men are inclined to associate any kind of emotional difficulties under the expression of "stress" instead:

> Ah I don't know anybody that talks about it in those terms really. It's just like "ah you know I'm happy, a bit stressed." Stressed is the classic catch all isn't it, lump everything under stress, yeah, a bit low or they'll talk about a particular issue, "like you know me and the missus are not getting on" or you know, "I don't know what the future holds you know." [. . .] If you're having an emotional, relationship issue, you perhaps pile all those issues into one thing. Nah blokes, my friends at least, don't really talk in those terms (Simon, 40–45 years. General public sample)

Mike said similar about men articulating and framing mental health difficulties as "stress":

> I think one of the words that's kind of been normalized, which it shouldn't have been, particularly in men, is stressed. "Ah I'm really stressed about it, ah I'm stressed." Well, that used to mean, stressed used to mean unhappy and nowadays if you said, "I'm actually really unhappy at the moment you know, work's bad, I'm really unhappy," that would be weird. To say, "I'm stressed," it's kind of the norm, it's like "oh yeah, everyone's stressed aren't they" and that gets used a lot. I think a lot of men in particular use that as a kind of guard, they say "aw I'm pretty stressed at the moment." They really mean, "I'm anxious and I'm tired, I'm angry and sad." That's a word they use to deflect from mental health, I think (Mike, 20–25 years. General public sample).

These accounts suggest that amongst groups of men, the admission of "unmanly" depressive symptoms might still carry with it fears of shame, vulnerability, and societal stigma (O'Brien et al., 2005; Emslie et al., 2006). The quotes above reveal how using the term "stress" might be acceptable within men's lives and conversations with others and may instead denote feelings of manly self-reliance and success through the notion that men become stressed through paid employment and the pressures of providing.

Ambivalence Towards Professional Support

In the experience of seeking out mental health support, several participants noted that cost, lack of time and availability of services, in particular waiting lists for counselling services, were practical hurdles participants spoke of having to initially navigate. Daniel explained that he sought counselling from a professional after a friend advocated the benefits of talking to a counsellor, however, Daniel's response was "but it's finding time." He appeared ambivalent in his efforts to seek out formal support:

> It's quite ironic that I'm doing this because about 3 months ago I just woke up and I had, I wouldn't call it a panic attack, but a bit like an anxiety attack. So, I tried to go to a psychiatrist, a psychologist. She wasn't able to fit me in, so I haven't gone. Yeah, I rung this woman up and typical man, sort of you know, can you fit me in, and she was like "no I can't take anybody on." Oh, forget it (Daniel, 30–35 years. General public sample).

In portraying his ambivalence, Daniel related help-seeking to wider discourses of masculinity through generalisations of what "typical men" do, seemingly to defend his reasons for not further seeking out professional help. What is noticeable here is that Daniel did make effort to ring the psychologist (having been encouraged by his female partner) yet was faced with the obstacle of a waiting list. This conundrum challenges the dominant discourse that men are reluctant to seek out help and instead recognises obstacles beyond men's control that can potentially impede men seeking support.

Another participant also discussed his intention to seek formal help for emotional distress but again implying an ambivalence, said he changed his mind due to the prospect of waiting lists:

> Andrew: But I did think once of asking the doctor if I could see a psychiatrist. Which would have to be a waiting list for it. The only service I had to have, was to get myself going, to up-

service myself. I couldn't ask anybody else to sort my problems out for me. I had to do it myself.
Interviewer: But you were thinking about asking?
Andrew: I was thinking about it at the time, yeah. Psychiatrist was on the book see but alas a time went by and that's it (Andrew, 66–70 years. Support group sample).

For Andrew, it seemed to be a combination of both availability of an appointment with a professional, the requirement for self-control of his own health (Robertson, 2007), as well as confidence in his own masculine self-efficiency that contributed to this. By noting how it was his job to sort himself out, without the help of anyone else, he positions himself in line with traditional ideals of masculinity, such as self-reliance, stoicism, and independence. This degree of ambivalence presented by these participants could be due to the type of help that they perceived as available to them, and the idea of waiting lists and relying on someone else for support which may threaten masculinity.

Attempting to Reframe Help-Seeking as "Normal"

Some participants' attitudes and assumptions surrounding mental health help-seeking altered throughout their accounts when retelling their experiences. James realized this change within himself and his perception on seeking mental health support. James had previously sought help from the GP which led to one-to-one counselling, something that he identified as particularly effective:

> It sort of just changed something for me. Sort of said, yeah if I break my leg, I go out to a doctor. It's the same thing. You need help, you need professional help, go see a doctor . . . (James, 60–65 years. Support group sample)

Participants who generally had more positive experiences and perspectives towards seeking professional help reframed the help-seeking process, attempting to normalize it. James' comparison of emotional distress to breaking a leg, in the way that it should be treated, highlights the way men might privilege the physical over the emotional. In response to potential vulnerability, he attempts to reconstruct traditional masculine ideals to view help-seeking as an active, positive, and strength-based perception action. Such comparisons were seen within other men's narratives in attempt to reframe and normalize mental health help-seeking through physical metaphors, and positioning disclosure of distress to actively deal with the issue:

> You know, I have a golf lesson once a month just to tidy up my golf swing, it's exactly the same as probably going to see somebody. Just talking through your issues, which is life (Daniel, 30–35 years. General public sample).
> If my pipes are leaking in the house, I don't just shut the bathroom door and hope it's going to go away. You know, you phone a plumber and get an expert in. But you know we don't do that do we, well men don't do they? (Simon, 40–45 years. General public sample).

These men showed awareness of the importance of seeking mental health support, pointing to a general, and more positive shift in hegemonic values to do with mental health and help-seeking, allowing for men to positively engage in help-seeking. Nevertheless, reframing help-seeking in this way and relating it to physical, masculine practices that concern "fixing things" may actually be reinforcing hegemonic masculine values. Simon also acknowledged the dominant discourse that men do not seek expert help. Simon started by saying "but you know we don't do that do we" but then restructures his sentence by saying "well men don't do they." Using the homogeneous terms "men" and "they" in his narrative, Simon attempted to distance him away from masculine stereotypes, as he had sought out counselling himself. Despite associating help-seeking with a sense of masculinity and reframing it in masculine terms, in articulating their experiences to the researcher, these participants purposively attempted to position themselves outside of the dominant narrative that men cannot and will not seek mental health help.

The Importance of Significant Others

Most participants who had sought formal help for distress explicitly acknowledged the importance of a significant other in the decision to navigate and seek out formal help. Through initially talking to someone close to them (including partners, parents or close friends) about emotional difficulties, participants were encouraged and supported to seek out more formal support, usually from the GP. Two middle aged men had spoken to their mothers about their emotional troubles who aided their help-seeking, Nathan said "I spoke to mum about it and that and I realized you know it was the best thing to do, to explain" (Nathan, 46–50 years, general public sample) and Steven said "I spoke to my mother I think, and I think it was mum who said you know just go and speak to somebody" (Steven, 56–60 years, general public sample). For participants who had spoken with professional services, initially disclosing distress to family and friends put them in a less vulnerable position and was an influential starting point that promoted formal help-seeking, as Samuel explained:

> It started off with friends, then parents, then the GP and then who they referred me to. Whereas I don't think I could have gone straight to the GP or the services. I think I needed to make that admission to somebody else I was comfortable with first and then that would have given me time to sort of process that and say yeah, I do need help (Samuel, 26–30 years. Support group sample).

There are different pathways to doctors, and people often use "lay networks" of friends, families or other individuals to help them assess and respond to symptoms (Smith et al., 2005).

Influential Cultural Milieu

Participants' help-seeking behavior was also influenced by what they perceived to be the norm within their own cultural milieu. In

some men's accounts, having friends who had sought help for distress further motivated formal help-seeking:

> Interviewer: Did you go to the doctors off your own back?
> John: Yeah. It was funny because I was talking to another friend. He was having something similar, and he described it to me as he just didn't know what to do for help and this depression was like a big wall in front of him and he didn't know how to get over the wall. He said he went to the GP and started just the talking therapies, and he took medication, and he described it as the wall started to come down and he started to see a way over it, and how to move on and that's exactly how it felt to me. I went to the GP, and I was really surprised, I just burst into tears and just sort of off-loaded everything which came as a–I didn't expect to do that. I expected to go have a much calmer conversation with him (John, 40–45 years. General public sample).

Seeing other men resisting hegemonic masculinity and disclosing details about their mental health and help-seeking can be so profound that it gives it legitimacy and permitted other men to also resist hegemonic masculine ideals. Specifically, John's account indicates the influence of descriptive masculine norms that are produced when a male observer sees what other men are doing in a situation (Addis and Mahalik, 2003: 10). When disclosing vulnerable emotions and feelings, men may hear important (male) others say that it is important to get help for distress or also observe men they know receive help. Seeking help and divulging personal experiences became normalized within John's social group (John is a gay man with a circle of male friends) and influenced his help-seeking behavior through social norms reproduced within that group.

Talking to Others on Their Own Terms

Many participants (10 of 19 men interviewed from the general population and 15 of 19 of men from the support group sample) had engaged in some form of talking therapy in the past. Some participants had accessed counselling through their workplace or university, others had been referred to services through their GPs and a few had sought out private counselling themselves. These men constructed the desire to just have someone listen. Some men recounted a preference to speak at length with a therapist over speaking to a relative or friend, which sits in contradiction to the theme that describes the importance of significant others in men's help-seeking pathways. For Shaun, it was having someone independent of the situation acknowledging the extent of his distress:

> To have somebody else say "yes, that's a shed load of shit" was cathartic enough for me to be able to contextualize, probably stuff that went way back to when I was a teenager. So that really helped me, just for somebody else to say, "yeah, that was difficult, it's no wonder you felt like that" (Shaun, 46–50 years. General public sample).

This relationship, whereby they are the ones choosing to disclose personal emotions, also allows participants to construct themselves as active and empowered agents in their relationships with formal support providers (Johnson et al., 2012). These participants did not completely abandon masculine ideals in their preference for talking, as making the decision to seek out therapy and knowing what they want out of that relationship signifies independence and autonomy. This also demonstrates men's resistance of hegemonic ideas around men and help-seeking and highlights a pursuit of an alternative masculinity that embraces and recognizes the value of disclosing emotions, albeit on their own terms. Additionally, it was preferable to speak to a third party, as someone who "won't offer an opinion" (Daniel, 30–35 years, general public sample). Oliver, also felt similar about speaking to a therapist:

> I think you're not feeling like you're burdening someone. If you talk to a friend, it can feel very much like you're giving someone else your problems to deal with whereas when you're talking to a professional, I felt much less guilty (Oliver, 30–35 years. General public sample).

Feeling like a burden or wanting to talk to someone independent is not necessarily distinct to men's gendered experiences of mental health support. These men, however, specifically perceived therapists as having detachment to their situation and observed them as having a job to do, precipitating more comfortable disclosure, and lessening any resulting shame or guilt. This theme notably challenges the dominant discourse surrounding men and the disclosure of emotions.

DISCUSSION

In recent years, men's mental health experiences have gained much more research focus, exploring the complex relationship between masculinity and men's health-related behaviors, including help-seeking. The findings in this paper build on research exploring men's mental health experiences, help-seeking, and its relation to masculine ideals, and further identifies more nuanced understandings of help-seeking practices and pathways that men might engage in. In an effort to move away from focusing on masculinity as a determinant of whether men do, or do not, choose to seek help, the paper prioritizes instead the different ways men can engage with mental health support seeking. The study provides a new contribution to the under-researched field of men's mental health by focusing on help-seeking of men who may, or may not have, received a formal diagnosis, thus moving beyond an often-sole focus on depression, and using a distinct sampling procedure in attempt to include more diverse experiences.

There are several important findings. First, men's participation in this study, and the emerging themes, support other studies that have found that some men do seek help for distress under the right circumstances and if it is accessible and engaging (Cheshire, et al., 2016; Seidler et al., 2016). Nearly all participants had sought help or at least attempted to seek help for some troubles in living, even if they had not pursued it further or utilized continued mental health support. The paper highlights the need to

acknowledge the varied and positive ways in which men can, and do, manage their own mental health, as well as noting the diversity of informal and formal help-seeking practices engaged in. This supports the argument made by Keohane and Richardson (2018) that instead of examining men as resistant to mental health help-seeking, we should question their ambivalence depending on the type of help available and the context in which they seek formal help (Keohane and Richardson, 2018: 167).

Second, the findings presented emphasize connections between masculinities and masculine expectations, and men's different help-seeking behaviors and practices. The first theme "using other terms to articulate distress," reveals that men might still have difficulty in recognizing and interpreting mental health symptoms and they may initially show reluctance to name and disclose personal issues as mental health difficulties, not identifying their experience as a pattern of mental health help-seeking. Articulating personal struggles as mental health difficulties might pose risk to hegemonic masculinity (O'Brien et al., 2005) and in communicating distress in a different way, not directly seeking out mental health help, these men attempted to guard their vulnerability, retain a sense of control, and protect their masculinity and masculine status (Johnson et al., 2012). Participants described how men might be more likely to use the term "stress" to articulate more personal troubles and this could be interpreted as an attempt to hold on to masculine status in times of struggle. However, the notion of "stress" could also be considered a statement of vulnerability but being perceived as a temporary and situational based vulnerability, it carries less stigma of ongoing weakness than traditional diagnostic terms. The men in this study who used different terms to articulate emotional troubles did however seek out some professional help, and this should be acknowledged despite them not explicitly recognizing it as a help-seeking pattern for psychological terms. This also points to the important role GPs play in recognizing and diagnosing distress, such as depression and anxiety, in men when they might articulate it in different ways (Cheshire et al., 2016).

Relating to the above, the theme "ambivalence around help-seeking" further points to how men may attempt to preserve notions of masculinity by deciding not to seek help, despite recognizing the need for it. This aligns with Robertson (2007) "should care/don't care" dichotomy that argues that because society values healthy practices and health as a moral responsibility, men must balance the masculinity requirement of showing that they do not care about health with the opposite belief that they should. However, as noted in the results, these men depicted a sense of confidence in their self-management of distress, emphasizing masculine identity through self-efficiency yet also portraying that they were willing to take responsible action for their mental wellbeing. Observed in the first three themes, participants drew upon discourses and values associated with hegemonic masculinity (Jeffries and Grogan, 2012; Johnson et al., 2012) when articulating their experiences. For example, one man describes having to sort his problems out himself and "service himself" after contemplating seeking professional mental health support, aligning with notions of independence and autonomy. This same participant was attending a community support group aimed at supporting the wellbeing of older men, thus highlighting a different pattern of help-seeking. The theme "reframing help-seeking" shows how participants reconstructed help-seeking practices to align with hegemonic masculine values and behaviors such as self-efficiency and taking responsible action to manage issues (Farrimond, 2012; Johnson et al., 2012; Sierra Hernandez et al., 2014). In normalizing and reframing help-seeking, these participants constructed themselves as active participants in seeking mental health help (Johnson et al., 2012) and drew on notions of hegemonic masculinity in more positive and proactive ways.

Third, the findings demonstrate how help-seeking is a process of engaging with different support opportunities in a variety of contexts, as highlighted in the themes "the importance of significant others," "influential cultural milieu" and "talking to others on their own terms." Wenger (2011) argues that we should view help-seeking as an interpretative process in which a recognized need is identified and in doing so, we should consider how men work with others in their lives to make sense of their needs. For men in this study, encouraging committed partners were prominent in men's help-seeking practices, whilst allowing them to maintain their male identity through legitimizing help-seeking. The influence of others in a man's social network (Addis and Mahalik, 2003), in particular seeing other men resist hegemonic masculinity and seek out mental health help, was so profound that it legitimized help-seeking and allowed these men to break down some masculine stereotypes and stigma attached to help-seeking. The social norms model (Sieverding et al., 2010) suggests that seeking help is influenced by what is commonly approved by important others and what is commonly observed as done. It is important to consider here though that where men's social groups hold more traditional and/or negative masculine norms about help-seeking and mental distress (e.g., "men do not get depression"), the influence may be just as profound and lead to resistance to seeking out support. The example of John presented in the data (a middle-aged, well-educated, gay man), who sought help following a conversation with a male friend, also points to the importance of noting the intersection of other social characteristics (socio-economic status, sexuality) and their influence on social group norms and men's behaviors.

The final important finding is that participants also renegotiated the performance of hegemonic ideals around men and help-seeking and placed value on the importance of talking about distress. The theme "talking to others on their own terms" points to men's active pursuit of an alternative masculinity that embraces connection and disclosure, albeit on their own terms. This supports previous literature that suggests the ways in which men can resist hegemonic masculine ideals and embrace alternative patterns of masculinity which enable them to positively engage with their mental health (Farimond, 2012; Johnson et al., 2012; Sierra Hernandez et al., 2014; Seidler et al., 2016). Prioritizing therapy and disclosing distress on their own terms allowed for men to incorporate a sense of hegemonic masculine values in an alternative way that allowed for open and sensitive disclosure to manage distress. This also highlights a shift in hegemonic standards over time, whereby it

might now be more acceptable for men to openly discuss distress and help-seeking, content, and context dependent (Chandler, 2021).

Implications for Practice and Limitations

By not applying a narrow, deficiency approach of what mental health help-seeking entails, the findings gather more nuanced insights into the help-seeking process and how it might look for different men in their everyday lives. Furthermore, by recruiting men from support groups, the research has also considered the reasons and motivations for why men do seek help for distress, and specifically the kinds of support that men might utilize. The attention to the diversity of ways men do seek help may assist healthcare professionals and practitioners to develop strategies for engaging men. Understanding how others can influence men's help-seeking behaviors can support guidance for how to facilitate help-seeking relationships among male clients and also inform tailored interventions for promoting men's mental health. The findings could inform such interventions by emphasizing the importance of positive social support relationships for assisting men to seek help and through drawing attention to the ways in which men can alternatively use masculinity to positively manage their mental health in their everyday lives.

Despite the above, the research comes with limitations. This paper has focused on professional mental health help-seeking, such as speaking to the GP or counselling, as well as informal help-seeking through family and friends, and it is important to acknowledge that men may also use other sites of help such as web resources or helplines, when experiencing distress. Furthermore, the sample consisted of atypical groups of men from South Wales, who were willing, and able, to talk about their distress experiences at length with a researcher. Men with experience of distress and more positive attitudes to help-seeking are more likely to volunteer to take part in research than those with negative views and experiences of mental health help-seeking. The study attempted to access the more "strong and silent" men through the unique recruitment procedure and the sample did consist of men who described how they had never opened-up about their experiences until the research interview. It was found that the female gender of the researcher and the confidentiality aspect of the research interview setting positively influenced men's willingness to share more personal experiences. On the other hand, this might have also had influence on the ways in which participants positioned themselves in relation to masculine discourses in the presence of a female researcher, as they knew the research was interested in experiences of distress *as a man,* which could lead to self-conscious performances of masculinity. For example, men may have tried to assert some masculine dominance in directing the conversation in attempt to minimize vulnerability. In addition, the sample lacks ethnic diversity, even with the attempt at recruiting men of diverse social characteristics. The researcher purposely attempted to approach men of ethnic minority background in urban city areas of South Wales, yet it was difficult to recruit any to take part. Experiences of distress and practices of help-seeking may differ for men from ethnic minority communities, and it would be beneficial for future research to concentrate on the recruitment of, and exploration into, the help-seeking practices of black and ethnic minority men. Despite this limitation, the findings presented extends the field in providing nuanced insights into men's broader mental health and aspects of men's help-seeking experiences and pathways in everyday life, including those who may or may not have received a formal clinical diagnosis.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/Supplementary Material, further inquiries can be directed to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by School of Social Sciences Research Ethics Committee of Cardiff University. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

The author confirms being the sole contributor of this work and has approved it for publication.

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Promoting Healthier Masculinities as a Suicide Prevention Intervention in a Regional Australian Community: A Qualitative Study of Stakeholder Perspectives

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Regionally-based Australian men have a higher risk of suicide than those in urban centers, with similar trends observed internationally. Adopting a place-based approach to understanding men's suicide and harm prevention provides contextual insights to guide localised opportunities for the development of tailored gender-specific interventions. Men in rural Australia are typically portrayed as embodying idealized masculinity–dominant and tough, upholding strength and stoicism in the face of hardship. Such values can increase suicide risk in men by reducing help-seeking. The Macedon Ranges Shire is an inner regional municipality with a population of approximately 50,000 people spanning across 10 regional towns and surrounding farming areas in Victoria, Australia. Understanding the influence of masculinities on men's wellbeing and help seeking behaviours in a regional context is vital in order to inform effective local suicide prevention efforts. The present research involved in-depth qualitative interviews with 19 community stakeholders (M = 49.89 years, SD = 11.82) predominantly working in healthcare and community services including emergency services and education. Using thematic analysis, interview transcripts were coded and themes inductively derived. Stakeholders identified three key areas for understanding suicide risk and wellbeing for local men; 1) localizing masculinities, 2) belonging in community, and 3) engaging men. Findings illustrate that addressing men's wellbeing in regional areas requires a multifaceted whole-of-community approach. While diverse, local expressions of masculinities were seen as contributors to men's challenges understanding their emotional worlds and reticence for help-seeking. Of vital need is to provide diverse opportunities for men to connect with others in the region, and offer inclusive spaces where men feel accepted, welcomed and able to meaningfully contribute to the community. Not only will this assist by bolstering men's sense of self, identity, and mental wellbeing, it may also provide valuable informal inroads to normalizing healthy

communication around mental health and seeking mental health care. These findings offer important suggestions for the promotion of healthier masculinities in regionally-based Australian men, which may help to improve wellbeing of these men and their entire communities.

Keywords: masculinity, suicide prevention, men's mental health, regional and rural mental health, help seeking

INTRODUCTION

Regional and rural Australian men are at higher risk of suicide relative to those living in urban centers (Australian Bureau of Statistics (ABS), 2020). This is a trend also observed globally (Hirsch & Cukrowicz, 2014). Various factors are thought to contribute to increased rates of regional and rural suicide including reduced access to mental health services, physical and social isolation, increased vulnerability to extreme weather events such as drought, fires and floods, and increased access to dangerous means such as firearms (Hirsch & Cukrowicz, 2014). Given that men are 3–4 times more likely to die by suicide than women globally (Institute for Health Metrics and Evaluation, 2018), research focus has recently shifted to understanding the gendered experience of suicide and the role of masculine norms such as stoicism and self-reliance (Pirkis et al., 2017). Research into masculinities has been guided by Connell (Connell, 1995; Connell & Messerschmidt, 2005), who discusses the ways in which gender is socially defined through everyday patterns of practice dependent on culture and context. Conformity to masculine norms, as defined by Mahalik et al., 2003), refers to "*meeting social expectations of what constitutes masculinity in one's public or private life*" (p. 3). These perspectives provide a model to understand how adherence to masculine norms may differ across contexts and environments, and thus have differential impacts on men's mental health outcomes (Wong et al., 2017).

Traditionally, Australian rural masculinities have positioned men as independent and tough individuals who exert dominance over their land, and are stoic in the face of hardship (Alston & Kent, 2008). This ingrained stoicism is intrinsically linked with cultural expectations of rurality (Roy et al., 2017; Kaukiainen & Kõlves, 2020) and masculinity (Seidler et al., 2016) both in Australia and overseas, serving as a significant barrier to seeking mental health care for rural and regional men (Cheesmond et al., 2019). While idealized versions of manliness remain to some extent, recent scholarship points to the diversity of masculinities, recognizing that men diversely express their gender, even in rural areas that may appear homogenous (Creighton et al., 2017). For example, Herron et al., 2020) found that within their sample of rural Canadian men, those in distress indicated a desire to talk about their mental ill-health, but felt that their rural environment lacked opportunity to do so, highlighting tension between their agency and existing structures, and the pressure to conform to normative stoicism and self-reliance practices.

Having local social support structures and an increased sense of community can serve as protective factors against psychological distress in rural men (Kutek et al., 2011). McLaren and Challis (2009) found that although depression is a key risk factor for suicidal behaviour, this relationship was not significant among some farming men who reported high levels of social support and belonging. This aligns with the interpersonal theory of suicide, whereby suicidal behaviour emerges in the presence of two key constructs: thwarted belongingness and perceived burdensomeness, in addition to an acquired capability to enact lethal self-harm (Van Orden et al., 2010). Thwarted belongingness, which can occur in the absence of reciprocally caring relationships, can lead to loneliness and isolation. These factors may be exacerbated in regional areas where geography of townships increases physical distance between men and their communities. Understanding factors associated with belonging and connectedness for men in their community may provide vital clues and potential inroads to protecting men from suicide.

Given the aforementioned influence of masculine norms on help-seeking, and comparatively high suicide rates of regional and rural men, particular attention should be paid to specific challenges for men within *their* community (Creighton et al., 2017). Adopting a place-based approach to understanding masculinities and mental health in rural and regional communities will assist in the development of tailored community policy and practice interventions (Cheesmond et al., 2019). Taking a relational view of place, environments can be viewed as dynamic and influenced by the changing mobility of populations as they move in and out of place borders, both daily and across the lifespan (Cummins et al., 2007). Hence, while men may live in small townships, they influence, and are influenced by, the place they live, their workforces, the people they interact with, and external cultural discourses.

The Macedon Ranges Shire in Victoria, Australia is an inner regional area with a population of just under 50,000, spread across 10 regional townships and surrounding areas (ABS, 2018). Of concern to local government and healthcare organisations, the region has comparatively high male suicide rates compared to state rates, and increasing family violence rates and alcohol-related harms for men (Turning Point, 2018; Crime Statistics Agency, 2020; Public Health Information Development Unit, 2021). This has prompted the need for place-based analyses of men's attitudes and harm-related behaviours, to provide insight into potential factors facilitating these patterns of harm. Place-Based Suicide Prevention Trial Sites (PBSPTs) were established in twelve communities across Victoria, Australia from 2017 to 2020 as part of the State and Commonwealth Government's suicide prevention strategy. The present study is a part of *The Human Code Project*, facilitated through the Macedon Ranges PBSPT (https://www.benetas.com.au/health-care/macedon-ranges-

health/the-macedon-ranges-suicide-prevention-trial-site), designed to determine the extent to which local men and boys conform to dominant masculine norms and the impact of this on men and boys doing and experiencing harm.

While the Macedon Ranges Shire retains an agricultural and industrial focus, the proximity to larger urban centers has brought an influx of population growth in recent years. Many men maintain employment in the nearby city of Melbourne or surrounding townships, commuting out of the region daily for work. The conceptualization of rural masculinities (e.g., Alston & Kent, 2008) focused predominantly on agriculture may not adequately represent men in this community. In this way, the Macedon Ranges may represent many inner regional areas in Australia (and internationally) where changing populations continue to cause demographic cultural shifts as the roles, expectations and expressions of masculinity diversify. As such, place-based research into local masculinities and mental health service provision for men is vital to understand the specific needs of communities, and to be able to develop tailored community driven interventions.

The identification of potential risk and protective factors for men's wellbeing within a specific community may facilitate upstream suicide prevention strategies focused on cultural change at a community level. This mirrors Australian place-based suicide prevention which seeks to build community resilience through a whole-of-community approach involving government agencies, community and healthcare organisations, and people with lived experience of suicide (Baker et al., 2018; Shand et al., 2020). Stakeholder views have been sought previously in male suicide prevention (e.g., Grace et al., 2018) and can aid in the development of practical strategies and increase the likelihood of implementation of such interventions (Wolk et al., 2018). Using in-depth qualitative interviews, the present study aimed to understand stakeholder perspectives of how local men enact masculinities, and how masculine norms influence men's wellbeing in a regional area. The findings will inform *The Human Code Project* and facilitate the development of healthy-masculinity focused initiatives in a regional community. More generally, the current research offers an example of localized qualitative enquiry into masculinities and men's wellbeing that may provide a guide for future community-based suicide prevention research.

METHODS

Study Background

The Human Code Project was commissioned by the North Western Melbourne Primary Health Network through the Macedon Ranges Place-based Suicide Prevention Trial Site with the purpose of identifying key data to inform subsequent program development for the promotion of healthier masculinities within the Macedon Ranges Shire. This project focused on developing local research knowledge of the attitudes and behaviours of men and boys in the Macedon Ranges, in order to contribute to the identification of healthy masculinity-focused approaches to reducing male suicide. Integral to the project was the input of local voices, and the use of local resources and skills to ensure the successful implementation of evidence-based initiatives within the community. A Project Working Group was established in September 2020 comprised of key local partners and stakeholders including council, local healthcare providers, suicide prevention and family violence networks, Men's Sheds, local sporting clubs and health promotion organisations, responsible for oversight and community input into the project. Note that the Project Working Group did not include any members from the study funder. *The Human Code Project* ran from September 2020 to August 2021 and involved a community-wide survey, interviews with community stakeholders, and interviews and focus groups with local men and women. The present study utilizes data from interviews with community stakeholders. This research was approved by The University of Melbourne Human Research Ethics Committee (2057593).

Study Sample

Nineteen stakeholders (52.6% female) ranging in age from 33–81 years-old (M = 49.89, SD = 11.82 years) working in the Macedon Ranges Shire completed individual interviews. Stakeholders consisted of healthcare and health promotion professionals (n = 8), community service, law enforcement or sports staff (n = 8), and education staff (n = 3). Average length of interviews was 45 min. A minimum sample size of N = 15 was determined a priori on the basis of the finding that 12 in-depth interviews is likely to result in data saturation (Guest et al., 2006). The sample was extended to N = 19 in order to obtain adequate scope across stakeholder professions on direction of the Project Working Group.

Data Collection

Participants were recruited through the professional networks of the Project Working Group. Community groups, local service providers, organisations and individuals that had expertise or experience working with boys and men were determined by the Project Working Group. Organisations and/or individuals were then contacted by the research team via phone or email to explain the study aims and interview process. Those who expressed interest in participating were provided with the study information statement and consent form. Stakeholders were sought from a range of community sectors including health care and emergency services, LGBTIQA+, youth and older people's community services, community sport, law enforcement, and education to ensure breadth of experience in working with local men and boys across age brackets. Participants were offered a $30 reimbursement via EFT transfer as recognition of their time. Following the provision of informed consent, interviews were conducted virtually using Zoom videoconferencing software (Zoom Video Communications Inc., 2019). Conducting interviews remotely via Zoom was beneficial in that it facilitated ease of data collection and overcame geographical barriers to participating in the research, particularly given the researchers were not located in the area of interest. Further, the online setting lowered the time commitment for participants who were often completing their interview during working hours. Of the 19 interviews, only one had notable disruptions due to an unstable internet connection. This was quickly overcome by using Zoom's dial in feature, allowing the

interview to continue smoothly. Unstable internet connection and/or lack of access to internet however may be limitations of using videoconferencing for qualitative interviewing, particularly when working in regional and rural communities where internet shortages may be more common. One disadvantage of using videoconferencing was a higher rate of disruption during interviews due to other people or external noise, however this was managed by the researcher asking participants to ensure they were in a quiet and private space for the duration of the interview, and by being flexible and adaptive if interruptions were to occur. Benefits and limitations of using Zoom mirrored those discussed recently by Oliffe et al., 2021). Overcoming the above limitations, Zoom was a successful and acceptable method for participants and researchers in this study.

Interviews followed a semi-structured interview schedule with key questions including "*What do see as the biggest risks to the health of boys and men in the Macedon Ranges community?*", "*How does the Macedon Ranges community influence the development of masculinity for men and boys in the region?*", and "*How could organisations in the Macedon Ranges help reduce the likelihood of men experiencing a mental health crisis, including suicide attempt?*" (See supplementary materials for complete interview schedule). The first interview was conducted jointly by researchers KT and SR. The remaining 17 interviews were conducted by one 24-year-old female researcher KT (BSc Hons) who was supervised by SR (PhD MPsych) who has significant experience conducting qualitative interviews with men. 16 interviews were individual and one involved two participants upon their request to be interviewed together. The researchers were not local to the area of interest and therefore had no pre-existing relationship with the participants or specific culture being discussed. The researchers were guided by a theoretical understanding of rural Australian masculinities (e.g., Alston & Kent, 2008), and preexisting knowledge of concerns in the area (e.g., high male suicide rates) which may have influenced perceptions of the area and subsequent data. KT kept memos during the data collection process noting any assumptions or biases that presented for discussion with the wider research team. Demographics (age, gender identity and professional sector) were obtained at the beginning of each interview.

Data Analysis

Data were analysed according to qualitative research techniques and reflexive thematic analysis (Braun & Clarke, 2006, 2019). Audio recordings of interviews were transcribed verbatim, and checked for accuracy by KT. Transcripts were deidentified and participants allocated a unique code. Data familiarization was firstly gained by reading the full data set in depth. Basic concepts were then identified inductively, and data segments were assigned to descriptive codes in NVIVO-12 qualitative software (QSR, 2018). Cross-coding of two full interview transcripts was undertaken by two authors (KT, MW) with incongruences discussed and consensus reached to ensure consistency in the coding analytics. Initial codes were then organized into broad themes to assist with organising the data to allow for further analyses. Iteratively, codes were subsumed and weighted to inductively derive beginning insights. For example, initial codes used descriptive labels that reflected direct meaning from participants (e.g., "*Banter and taking jokes as a key part of masculinity*", "*Driving related to masculine identity*") and these codes were subsumed into categories representative of broader patterns in the data such as '*Regional* "*blokey*" *culture*'. In further analyzing the coded data, themes and subthemes were developed, defined, and re-named to pre-empt the discrete findings. For example, '*Regional* "*blokey*" *culture*' was subsumed into the wider subtheme '*Embodying local masculinity*'. These analytic processes included researcher meetings (SR, KT, JLO) to discuss the data and select representative illustrative quotes, which occurred regularly in the drafting of the findings and current article. Masculinity (e.g., Connell, 1995) and gender and place (Massey, 2008) frameworks were drawn upon to theorize and contextualize the findings within the men's mental health literature.

TABLE 1 | Summary of themes and subthemes.

Theme	Sub-theme
Localizing masculinities	Embodying local masculinity
	Restricting mental health help-seeking
	Breaking the masculinity mould
Belonging in community	Community connectedness as a requisite to wellbeing
	Linking social disconnection to distress
	Creating opportunities for connection
Engaging men	Authenticity forefronting intervention
	Tailoring language, program content and delivery

FINDINGS

Three overarching themes were derived from the interview data; 1) *Localizing masculinity* 2) *Belonging in community*, and 3) *Engaging men*. Within each theme, inroads for intervention as suggested by stakeholders are discussed to provide potential direction for making meaningful change. Themes and subthemes are presented in **Table 1**.

Localizing Masculinities

The first theme, localizing masculinities discusses stakeholder perspectives about regional men's expressions of masculinity comprised of three subthemes. First, '*Embodying local masculinity*' summarizes the culture prevalent in the area in regards to enforced gender roles and the continued influence of masculine norms such as stoicism and toughness. The impact of these masculine expressions on men's mental health is then detailed in the subtheme '*Restricting mental health help-seeking*'. Despite the traditional culture referenced, stakeholders noted experiences of men who step outside of the perceived norm, and the challenges they may face in doing so were discussed in the subtheme '*Breaking the masculinity mould*'. Here, strategies outlined by stakeholders as ways of promoting and sustaining healthier masculinities in the area are presented.

Embodying Local Masculinity

Stakeholders referenced a somewhat traditional and conservative Australian culture in the Macedon Ranges, where gender roles

were prescriptive and policed. Regional men were seen as needing to conform to expectations of being the main family provider and protector figure. While individual variability in whether men fulfill these roles was accepted, the lack of diversity and the limits to role modelling regarding alternate expressions of masculinity (and minimal opportunities for men to step outside of these roles) was seen as a contributor to pressures faced by men of all ages:

> "Growing up in what is essentially a small country town I think can be hard for men, in that sense of, you need to stick to kind of traditional male roles." (Female, 40–45 years).

Referencing the '*blokey*' culture of the Shire, some stakeholders spoke of masculinity being intertwined with sport, alcohol and drug use, and risk-taking behaviours such as hazardous driving. At the same time, conversations between male peers related to personal difficulties were seen as rare–and perhaps unlikely. Instead, friendship and '*fitting in*' relied on an ability to '*take a joke*', including displays of toughness, bravado and care-less expressions. These outward displays of masculinity were linked with maintaining a sense of power:

> "And that's about getting your license, having a car, having kind of power, I suppose you would say, and feeling like you have achieved something. Whereas I find the more female identifying people don't. That's not as much as part of their identity." (Female, 55–60 years).

Restricting Mental Health Help-Seeking

The influence of traditional masculine norms such as stoicism and emotional restriction on men's help seeking behaviours was apparent across stakeholder interviews. The majority of stakeholders referenced men's challenges in displaying or talking about their emotional states. This was guided by a cultural attitude of '*she'll be right*' stoicism which was seen to be enhanced in the regional context:

> "Their response is just informed by this picture of masculinity, which is like a squinty eyed, grit your teeth, in English we'll call it stiff upper lip, that this picture of an unfeeling stone, which is I think brittle, not tough." (Male, 50–55 years).

Stakeholders described men in the Shire as often having low emotional awareness, with many lacking the skills to talk effectively about their emotional lives. For the most part, this was framed as a learned state whereby men (and boys) were socialised from a young age to refrain from vulnerability and expressing emotions, and therefore lacked opportunities to develop skills to identify and communicate diverse emotional states:

> "They're less likely to seek emotional support or psychological support than women. And that is just a construct of how they've been taught. I guess through that, not just being raised, but through culture that, "he'd just pull it together and keep going". Women traditionally talk to each other, they"re supposed to need support, whereas men are supposed to be the supporters." (Female, 45–50 years).

Stakeholders reflected that these characteristics may be amenable to change. Increasing awareness and education efforts for men and boys regarding identifying and managing emotions was seen as a potential way to support better self-management of mental health and recognition of distress in peers:

> "You've actually got to start educating these guys on the language. You've got to bring it right back, right, a massive re-build. And actually go, "This is what you say. This is how you feel." "Hey, this might add up to thoughts of suicide, yeah? Maybe you need to pay attention and listen to what they're talking about, and acknowledge it and hear it." And then . . . talk about being a good listener, which is really important." (Male, 45–50 years).

Despite their perceived inability to talk about their mental health, men were sometimes seen to rely heavily on their female peers for emotional support, nurturing and managing distress. This may suggest that men confide their concerns to a trusted person, especially if this person is a partner. Fostering acceptable and comfortable environments between male peers could be an important step to building open communication channels. Educating, role modelling and supporting men to have open conversations about mental health with their male peers was seen as a vital part of suicide prevention:

> "They're life-saving conversations. 'You'll be right, she'll be right,' no. But, 'I love you. I'm worried. You should go and see a doctor. I've been to see a counselor.' And they're life-saving conversations." (Male, 45–50 years).

Breaking the Masculinity Mould

While stakeholders reflected on a traditional picture of masculinity being prevalent in the Macedon Ranges, alternate ideas of what it means to be a man were increasingly apparent within the community. For example, one stakeholder described his understanding of masculinity as one that involves emotional awareness and empathy, and rejected typical norms of stoicism and dominance:

> "I tend to find a trait of masculinity to be more empathetic and more caring and more outward reaching to try and help people or check in on people rather than inward facing and trying to bottle up things and fall into those very typical type gender roles of being a provider and the dominant figure in relationships and society." (Male, 30–35 years).

Some stakeholders spoke of experiences with men and boys who are increasingly questioning the benefits of subscribing to the restrictive masculinity with which they are presented. Young men in particular were seen as drivers of change as they look for

alternative ways to express their masculinity. This decision to deviate from the norm presents challenges for men as they may struggle to maintain a sense of belonging while engaging in and promoting healthy behaviours and traits that challenge outdated masculine stereotypes:

> "There are a lot of young men who are questioning those . . . outmoded, harmful stereotypes and models of masculinity, who want more, who may look at older men, their fathers and grandfathers, and who actually feel some compassion . . . young men who are looking to redefine a new kind of masculinity, a new way of doing manhood and boyhood. And I feel there's quite a lot of openness and some real resilience, it's not easy to challenge those kinds of societal norms and it's not easy to stake out a place." (Male, 50–55 years).

Affirming men to continue to expand their understanding of what it means to be a man in the Macedon Ranges, and actively supporting those who do display alternate pictures of masculinity was seen as a vital way to ensure those behaviours and traits are modelled and reinforced within the community. Empowering men to stand up, be involved and act as positive community role models were articulated as ways of assisting in creating meaningful grass roots community change. This was viewed as particularly pertinent when trying to create change around behaviours that predominantly are seen in men, for example in relation to family violence:

> "And I think that needs to continue, to keep having that conversation and getting more Male Champions of Change, for want of a better term to actually stand up. If we talk about domestic violence, family violence, there's been a lot of female leaders in the community standing up, we need more males." (Male, 50–55 years).

Importantly as articulated above, the expression of masculinities that contest dominant (and damaging) norms may jeopardize the need to fit in with the peer group, a phenomenon which seems to be heightened in the regional context due to limited social circles available. Social standing, which likely pertains to complicity in sustaining and/or conformity to the norm, was viewed as an important consideration by some stakeholders when identifying community role models who are likely to have the most impact:

> "How do you find the young men who are courageous enough, but also have enough social clout in a way, to be the ones to stand up? Because I think that's often what it is about, is having legitimate, believable, real people in the community that are respected and well regarded." (Female, 40–45 years).

Characteristics such as kindness, empathy, self-awareness, respect and open communication were viewed as important to uphold and promote via community role models who actively exhibit these characteristics and are celebrated for doing so. These behaviours were more linked to normative femininities, which may explain some men's reluctance to be seen as embodying these 'softer' sides. As highlighted below, men who exhibit these qualities within the accepted framework of masculinity might be most useful in shifting norms to promote and sustain healthier masculinities:

> "Men that are self-aware and open, welcoming and embracing. I guess to tie into some of the typical masculine rhetoric, a good bloke type narrative but still someone that can upend the very negative aspects of masculinity." (Male, 30–35 years).

Belonging in Community

Across interviews, stakeholders referenced men's social relationships, community connections and desire to fit in with the norm as essential to their wellbeing, represented here in the theme *belonging in community*. First, the benefit of strong social ties for men and boys is discussed in the subtheme '*Community connectedness as a requisite to wellbeing*'. The impact of impeded belonging is then articulated in the subtheme '*Linking social disconnection to distress*'. Stakeholders suggestions for '*Creating opportunities for connection*' as a way of improving men's wellbeing are outlined.

Community Connectedness as Requisite to Wellbeing

Many stakeholders highlighted social and community connectedness as requisite to wellbeing for men in the region. Men were seen as benefiting from strong social ties within the community when they were able to muster relationships involving a reciprocity in giving, as well as receiving support:

> "I think it is about being involved, being part of someone, a family, a community, a something, so that you are, the men are important, they've got a need, they've got a reason to live, whatever that might be." (Female, 60–65 years).

Participants reflected that a sense of belonging, purpose and acceptance within the community, stemming from strong social networks, helped protect from psychological distress and suicide risk in a two-fold way. First, being part of a social network (whether family, peer and/or community group) provided men with a way to engage in healthy communication and relationships, often while partaking in activities that were enjoyable and enriching. Second, trusted social connections offered opportunities for a vital link to supports for men when needed. As men may be hesitant to connect with formal community-based mental health services, strong social networks could provide intermediate informal support and, with the right mental health awareness and help-giving, allow for a trusted link to more formal services to be made when needed. As noted by a male stakeholder, fostering a "*real sense of community . . . where people look out for each other . . . will really help to create the glue of the society that people can actually feel supported" (Male, 30-35 years)*.

Men were perceived as having few opportunities for social connection, and/or were less likely to prioritise social

connectedness relative to female peers. Although many factors may contribute to men's difficulties creating and maintaining social connections, stakeholders brought to light several key contributors. First, men's work and family commitments could pose barriers to prioritising their social life. This may be particularly pertinent in regional areas where a large proportion of the workforce are based outside of their townships, contributing to long commuting hours that keep local residents away from their families and communities for longer. Second, men were perceived as taking less initiative (compared to women) in leading or attending social or community groups. While sporting clubs were something of an exception and viewed as an integral part of the community providing men with vital opportunities for social interaction and support, few alternate avenues for men to connect with the community were mentioned by stakeholders. In particular, the challenges for younger men in finding time and avenues for social connection with peers were highlighted:

> "I think there's just not the opportunities for some of the younger people in town to actually contribute to the community. They go to school outside of town, they come home, they sleep (at) home. They don't have that opportunity within their community to even catch up with lots of friends or peers or other people in the community." (Male, 50–55 years).

Linking Social Disconnection to Distress

The effect of limited opportunities for local social connection was apparent to some stakeholders who referenced isolation and loneliness as contributing to distress in the men they saw and worked with. Specifically, the impacts of social disconnection may be heightened for those residing outside of townships in the Macedon Ranges. These men were deemed to have less opportunities to interact with other members of the community, and experienced inherent challenges with accessing social support services:

> "If they feel like they can't talk to people or reach out or just become part of the community, I think men often feel on the edges of community unless they're involved in sports . . . for older men, things like Rotary or Lions, I think they often feel a bit alone and I guess that's really tricky." (Female, 40–45 years).

Social isolation was viewed as a place-based concern for the community as difficulties with transport and physical distance between town centers contributed to men's resistance and/or inability to engage with social and community groups. In addition to the structural barriers of transport, the regional context could impede men's sense of belonging. This was discussed in the context of difficulties finding like-minded male peers in a small community. The expectations for how men are, and how they behave, were significant here, especially in relation to age. For those young men who visibly operated outside of the accepted or mainstream ideal of what it means to be a man, there were "*limited options for how young people can see themselves and who they can be, and where they can connect, and belong.*" *(Female, 40–45 years*).

Creating Opportunities for Connection

In order to increase men's social and community connectedness, stakeholders suggested multiple avenues to provide opportunities for men to both make, and maintain social connections. The need for a diverse range of appealing activities and social groups for men was communicated by stakeholders, suggesting a need to expand beyond the existing opportunities and provide more spaces for men with varied interests to feel welcomed, included and able to contribute. Existing groups such as local sports clubs, Men's Sheds, Rotary and Lions clubs were seen as a vital and beneficial part of the community, offering a place for some men to gather and connect over shared interests, concerns or activities. Stakeholders reflected that informal gatherings and spaces that provide a place for men to talk with peers help to reduce the stigma of discussing mental health concerns. The extension of these models into wider community structures that appeal to other demographics, and age groups, could provide an inroad to connecting more men with their community and fostering the development of healthy social relationships:

> "I think we need to broaden our range of opportunities to offer people. So Men's Sheds are great, but they will apply to a number of people. Organizations are great too, but a lot of it is, I just think about getting to know the person and really working out what they want. What's going to be beneficial for them rather than us as organizer or for us offering situations for them to come to" (Female, 60–65 years).

Having strong social connections was not only seen as a potential protective factor against psychological distress, giving men a sense of belonging, it was also envisioned as a way for men and boys to connect with services if and when distress occurred. Trusted peers and friends can not only provide informal emotional support, but often are able to encourage or recommend professional support if they have the knowledge and skills to do so. In particular, stakeholders stressed the importance of boys and men being able to choose their potential support figures; who they would go to if they needed emotional support, before reaching the stage of needing crisis support. Here, introducing health promotion messaging around maintaining mental wellbeing, promoting healthy peer relations particularly male-male relations, and identifying key support figures may be a vital step to increasing men's comfort and willingness to access services:

> "I think this whole education thing (is important) about what is good mental health? Teaching people about how to be well and stay well . . . I think it's really important with young people to get them to identify who they would talk to if they were struggling, before they struggled, not when they're struggling . . . And what it does is it then makes for a much more resilient young

person, who makes a much more resilient older person, which then hopefully makes them produce resilient young children." (Female, 60–65 years).

Engaging Men

Across interviews, stakeholders highlighted various ways in which local programs and initiatives can better assist men, both by reaching out and engaging with those who are resistant to seek help, and by better responding to those who do access services. Successful approaches were seen as needing to center around men's individual experiences, strengths and work within a positive masculine framework, outlined in the subtheme '*Authenticity forefronting interventions*'. The second subtheme '*Tailoring language, program content and delivery*' then articulates the specifics of how programs may seek to achieve this through tailoring language and content for men.

Authenticity Forefronting Interventions

Stakeholders highlighted the need for a person-centered approach when working with men and addressing male distress. Recognition of diversity within men, alongside the specific needs, experiences and expectations of each man when accessing services or programs was seen as an important base by stakeholders. Programs and services that engage men's agency by lobbying them to contribute their skills and communicate their wishes, built on a philosophy of "doing with and not doing to" were framed as key to successful programs and community change.

> "Everybody has skills and strengths, and I think we need to give them opportunities to share those. And once again, it goes back to what opportunities are we putting out there for people to put their hand up and say, 'Yeah, I can do this. I can be part of this'." (Female, 55–60 years).

In addition, stakeholders discussed taking into consideration the activities, spaces and groups that men already engage and interact with, and utilising these to create meaningful change in a way that feels familiar and comfortable for men:

> "It's just creating things that men feel comfortable with, working within masculinity to change it, if that makes sense. So trying to reach men on their level and then shift the parameters a little bit at a time, I think is important." (Female, 45–50 years).

Given the importance of sporting clubs in the region, stakeholders saw a key opportunity for club leaders to advocate for mental health help-seeking and provide support to men in the community in a space that is familiar:

> "Before a game, break the ice and say, "Listen, anyone suffering from mental health or they think need to talk to somebody, come over to the club rooms anytime. We're here for you." Just get out there and say it on loudspeaker. Then as a club, you're advocating that it's okay to have some problems." (Male, 50–55 years).

Some stakeholders discussed the importance of actively promoting a safe space for vulnerability through open communication and modelling of healthy behaviours by program leaders. When men are provided with a "*safe, controlled, supportive environment*" *(Male, 50–55 years)* they are more likely to be willing to engage in discussion around mental health which may help alleviate some of the stresses caused by pressure to manage distress on their own, and allow services to respond to the distress accordingly:

> "Of course they're not going to talk about it, unless you create the right place and space for them. These services, in all fairness, can't do a whole lot if the bloke's not admitting what's going on for them." (Male, 50–55 years).

The value of championing lived experience as a way to connect and engage with men was discussed by stakeholders. By norming experiences and struggles, authentically sharing lived experiences was seen as a way to create meaningful connections, provide support, education and hope to those who may be going through a similar situation:

> "With something as important as mental health, and so much fantastic lived experience where people have come out the other end a better person for that experience and got through some really tough times, having them share that experience I think's really important. If we can try and promote those people to, I suppose to tell their story and what they went through, what worked for them, what didn't work for them, because someone will always be able to relate to that, and someone else will be able to relate to someone else." (Male, 35–40 years).

Tailoring Language, Program Content and Delivery

Language was seen as a key tool in the provision of a men-centered approach, with stakeholders arguing for an increased awareness of language that engages with men and allows them to relate to, if not lead, the conversation. Men were seen to benefit from a direct, straightforward conversational approach that provides information in a way that is clear and easy to understand:

> "Changing language about how we talk about things is really important, including men in the conversation, because I think a lot of the time they're not included and it's seen as the women's responsibility to fix emotional problems." (Female, 45–50 years).

Additionally, removing explicit mention of 'mental health' and other associated words from campaigns and programs may help men engage better by minimising the stigma felt when discussing their emotional concerns. Instead, framing the conversation around stresses and management experiences or behaviours that men recognise and relate to might make them feel able to engage with the conversation, and open doors to continue discussion and education around mental health and wellbeing:

> "If you had . . . "Are you suffering mental health? Go and see a doctor." I'd be thinking, if I'm reading that, everyone's looking at me. Why not target male toilets in the public facilities with advertisment? Without saying to them, "This is to address your mental health." Like, "Have you been feeling low lately? Have you thought about joining a local sporting club?" (Male 50–55 years).

Normalising behaviours in a non-judgmental format was also seen as a key component to engaging men. Being upfront and openly talking about struggles and problematic behaviours may help to destigmatise and validate men so that they engage the conversation and consider accessing appropriate services. In addition to educating men about the negative impacts of their behaviour for both themselves and others in a non-judgmental forum, facilitating their skill development to navigate similar situations in healthier ways in the future may help to prevent harm to both themselves and others:

> "If I come back to domestic violence, a lot of the language in domestic violence is about women. And I think it's the men that actually need to be targeted in those sorts of campaigns. So even just calling it violence against women or domestic violence, it's violence men do. I think we need to actually really start speaking the truth about those things, because often perpetrators of that sort of violence are people in crisis. So if the support is given to them, then it helps." (Female, 45–50 years).

Using positive framing and leveraging men's strengths was seen as a key way to increase engagement in mental health promotion efforts. In particular, reframing masculine norms may show men how they can better engage in healthy and open communication, without feeling threatened by the perceived loss of masculinity. For example, framing vulnerability as strength might help men to feel more comfortable in standing up and seeking help, if as a result they are viewed as courageous by their peers and community:

> "Vulnerability is the ultimate sign of courage. So, men want to be seen as courageous. So, utilizing the things that men want to be seen as, but showing the softer side of that, that actually is a strength." (Female, 40–45 years).

Additional strengths that could be threaded into communication with men in the context of service delivery or programs include men's strong sense of care and protection for their loved ones, which may motivate them to look after their health for those around them. Furthermore, there was a sense that the social pressures which have caused men to remain stoic have also built resilience which can be leveraged as hope. Finally, stakeholders noted a willingness of many men to learn and put in the work necessary to solve problems and create positive change, once given the space and time to do so:

> "I think often there is that capacity to . . . do the work. So they go, "Okay. What do I do?" There is a real eagerness to work on some of those things, and . . . once you've set up a safe space, once someone really gets a bit of trust and understands that you are genuine, I think there's a huge capacity [for change]." (Male, 50–55 years).

DISCUSSION

The present study adopted a place-based approach to male suicide prevention by describing the challenges and opportunities that exist for men's wellbeing, and the role of masculinities in these, within a regional Australian community according to local stakeholders. The three themes outlined represent key areas of consideration in increasing wellbeing of regional men and boys in order to reduce suicide risk. The contribution of local expressions of masculinity to men's social relationships, wellbeing and help-seeking behaviours were key challenges for many stakeholders, reflecting a need to increase visibility of positive expressions of masculinity through promoting healthy role models for boys and men. Evident in stakeholder accounts was the importance of bolstering men's sense of belonging in community through providing wide-ranging opportunities for social connection and contribution. Practical strategies for engaging with men through gender-sensitive approaches and a strength-based framework were endorsed by community stakeholders, giving key insights for the development of future community programs and initiatives.

Localizing Masculinity

The characteristics of masculinity spoken of by stakeholders suggest that many men in a regional community adhere to masculine norms of stoicism and emotional restriction, and face pressures to align with idealized masculine roles of being the main household provider and protector figure. Stoicism was much cited in the interviews as a characteristic of men that hinders their ability to cope with and seek help for mental health concerns, as per previous literature (Seidler et al., 2016; Cheesmond et al., 2019; Kaukiainen & Kõlves, 2020). Most stakeholders positioned regional men as especially unlikely to talk about mental health concerns, displaying high emotional restriction or lacking the literacy, modelling or skills to adequately discuss emotional distress. While many men may face challenges in disclosing mental health concerns and expressing emotions that threaten masculine status (River & Flood, 2021), recent research points to the importance of recognizing the agency and structural contexts in which men's talk does and does not occur (Chandler, 2021). Stakeholder (and possibly broader community) assumptions around men's disclosure and communication skills may underestimate the power of place for silencing men in this regard. As illustrated by the findings, stakeholders are aware that men may better respond without explicit mentions of "mental health", and yet an assumption remains that men should be persuaded to talk openly about just that. Listening instead to the men who *are* communicating about emotional stress via their preferred disclosure methods and amplifying this may assist to shift the notion that "men don't talk".

Men's disclosure patterns in times of stress vary both between and within men responding to diverse time points and contexts.

As argued by Schwab and colleagues (2016), in emotional disclosure men can present identities that are both resistant and complicit with traditional masculine norms as they navigate the conflicting needs of social connection and presenting as appropriately masculine. Healthcare workers and broader community members should aim to move away from the conceptualization of individual men as either "masculine and emotionally repressed or sensitive and open" (p. 305), and instead be attuned to the ongoing movement between these states. Importantly, recognizing the fluctuation of men's willingness to disclose may provide markers of growth and resistance to change that can allow listeners reflexivity in responding to men's changing needs (Schwab et al., 2016). Consequently, as mentioned by some stakeholders, communities should seek to understand the contexts in which men *do* feel comfortable to share their experiences, and what it takes to create safe spaces to affirm and work with men's disclosures. As argued by Herron and colleagues (2020), men's perception of the lack of appropriate spaces in regional and rural areas may significantly limit the public community-based sharing of vulnerabilities.

The importance of context in men's perceived inability to talk about their mental health was highlighted by the findings that men were seen to rely heavily on their female peers for emotional support, nurturing and managing distress. This may suggest that men confide to talk about their concerns with a trusted person, especially if this person is female. The reasons for this were unclear, but may relate to men's concerns regarding becoming distressed in the company of male peers and perceptions that this may be ridiculed, unacceptable or intolerable, or that their disclosures may not be held with appropriate care or respect (McKenzie et al., 2018). Further, given stakeholder observations of male peer relationships centering around banter and humor, it is likely that there is limited space for expressing vulnerability within such friendships. Recognizing the diversity of men's patterns of making and maintaining social relationships and understanding the ways in which men do pursue emotionally supportive relationships may help to promote healthier connections among men (McKenzie et al., 2018).

Despite the above concerns, diverse expressions of masculinity were apparent in the region, according to stakeholders, with a perception that younger men tend to value openness, resilience and compassion. The specific contributors to the development of these more positive expressions of masculinity however were not clear to stakeholders, and further research aimed at understanding how this group of men have formed these values may be beneficial. As highlighted by stakeholders, moves to reject rigid masculine norms longstanding in the community may result in men being othered, with increased difficulties finding like-minded peers to form strong social networks with. In a somewhat policed community, existing within the dominant masculine norm allows men to maintain a sense of belonging, paramount for wellbeing. However, given that adherence to masculine norms is linked with increased distress and harm behaviours (Wong et al., 2017), men should be encouraged and supported to embody healthier masculine states and ways of interacting. Young men in particular may be experiencing confusion around their roles and what is expected of them, which can often result in 'masking' as more manly (Vandello & Bosson, 2013; Wilson et al., 2021). Increasing men and boys' confidence to recognize and reject harmful norms, and to be their authentic in their own masculine identities may decrease anxiety related to perceived threats to manhood, and promote positive health behaviours. Utilizing this positive masculinity framework, (Wilson et al., 2021), young men and boys can be supported into more positive psychosocial trajectories through facilitating connectedness and authenticity. Strategies aiming to change attitudes and promote healthier masculinities should consider how to do so in a way that allows men to maintain community belonging and support, to reduce further ostracization and isolation.

Belonging in Community

Strong social connections fostering a sense of belonging were seen as a key pillar of men's wellbeing and protection against suicide, mirroring much existing literature and theory (McLaren & Challis, 2009; Kutek et al., 2011). Stakeholders referenced men's disconnection as a contributor to loneliness and isolation that they viewed as precursors to distress in many of the men they worked with. In line with the interpersonal theory of suicide (Van Orden et al., 2010), high prevalence of male suicide among regional communities may in part be explained by a heightened sense of thwarted belongingness flowing from physical isolation as well as misfitting with dominant ideals of masculinity (Oliffe et al., 2019a). Perceived burdensomeness was not strongly apparent in stakeholder accounts, possibly attributable to burdensomeness being an internalised and private construct. Data from *The Human Code Project* community survey will be able to verify rates of perceived burdensomeness in subsections of the community. Men high in burdensomeness may have been both less likely to be in contact with the stakeholders interviewed (e.g., healthcare workers), and less likely to disclose a sense of burdensomeness if they were. Further research with men in regional areas is required to examine the influence of burdensomeness on wellbeing in this population.

Rural and regional areas can present a narrowness of acceptable behaviours, particularly for young men, and provide few opportunities for those who move away from the traditional masculine norms (Coen et al., 2013; Creighton et al., 2017). Bolstering community connection by affording men increased diverse opportunities to expand their social connections may be a lynchpin for protective actions against male suicide behaviour in regional communities. The communal nature of regional areas can be capitalized, promoting formal and informal social networks and help giving, for example through peer support programs (Hirsch & Cukrowicz, 2014). Men's Sheds[1] were spoken of highly by stakeholders and offer a well-

[1]Men's Sheds are community-based nonprofit organisations accessible to all men within a community with the primary purpose of providing a safe and friendly environment for men to work on meaningful projects in the company of other men (see https://mensshed.org/what-is-a-mens-shed/). Aimed at advancing the health and well-being of their male members, there are over 1,000 Men's Sheds in Australia and increasing numbers worldwide.

established government funded model of peer support shown to provide wellbeing benefits for men and increase sense of belonging (Waling & Fildes, 2017; Taylor et al., 2018). The success of the Men's Shed model has been attributed to its fit within a masculine framework outside of typical healthcare contexts, where men are able to maintain independence through partaking in shared activities while creating emotional bonds and engaging in healthy social peer relationships. Men Shed's however are normally targeted to, and engage older men. Initiatives aimed at enhancing belonging that are sensitized to men's level of comfort in going beyond traditional masculine spaces are therefore needed for younger and middle-aged men. Structural, community based social initiatives may be more accessible and appealing to many men than individual approaches (e.g., individual therapy) as a means of coping with stress and increasing sense of community and belonging (Kutek et al., 2011).

Stakeholders reiterated the cultural importance of sporting clubs as a space where men gather and socialize, and as structures that are seen as key drivers of township cultures. Sport is an integral institution in the development and upholding of masculine ideals, through the valuing of athleticism, toughness and competitiveness (Burgess et al., 2003). Indeed, discussion of mental health from public sporting figures has been proposed to be potentially beneficial for young male help-seeking, by connecting vulnerability and help-seeking to aforementioned masculine ideals (Swann et al., 2018; Walton et al., 2019). In a more applied sense, sport settings provide men with the opportunity to socially connect in with community (Chamravi et al., 2020), and can be utilized as men-friendly community settings for health promotion messaging and mental health programs (Oliffe et al., 2019b). Programs of this nature that have been developed internationally (Dixon et al., 2019; Wilcock et al., 2021), and in Australia have aimed to promote early intervention and help-seeking (Vella et al., 2018; Vella et al., 2021), increase parental awareness of mental health (Hurley et al., 2020) and increase men's self-efficacy, social connectedness, and leadership skills (Chamravi et al., 2020). The implementation of evidence-based programs like this into regional sporting organisations may be a key step forward to increasing belonging and connectedness for many men, and reducing stigma surrounding mental health help-seeking.

Many stakeholders spoke of the increased time stress for men working outside of the region with long commuting hours. While their workplaces may provide opportunities for social networking, having meaningful connections within their immediate community was seen as important. These men, likely within the age range of 30–60 years-old and often parents, represent a key gap in the provision of social groups for connection as they tend to fall outside of the target audience for sporting clubs aimed predominantly at younger men, and Men's Sheds aimed at retirees. Understanding the needs of these men and providing opportunities for connection that are appealing and accessible within their time constraints is an important consideration. Additionally, equipping men with the social skills and confidence to seek out and maintain social connections with those they meet incidentally (i.e., through work or family commitments) may assist in overcoming barriers to prioritizing social connection for men who are time-poor. More work could be done to support and connect in specific groups of men, for example new fathers as they navigate changing roles, to ensure social connection is not lost to competing priorities. Importantly, communities should recognize that sporting clubs and other environments that embody traditional masculine qualities will not appeal to all demographics of men within a given region, and care should be taken to ensure choice in activities offered and provide safe spaces within communities for all men and boys. Consideration of the additional challenges faced by minority groups of men including LGBTQIA + men, culturally and linguistically diverse men, and Aboriginal and Torres Strait Islander boys and men is essential to delivering appropriate and identity affirming social structures for these groups. Further research is required to identify what these might look like in an inner regional community.

Engaging With Men

As a way of overcoming the above concerns, stakeholders emphasized the need for a gender-sensitive approach to health promotion and behaviour change that recognizes the strengths and interests of individuals and works within a positive masculine framework to create reform. Authenticity in engagement with men and interventions coming from within the community were seen as key by stakeholders, who discussed the need to identify community role models who endorse positive masculine traits and who are respected, relatable and able to engage with the male population. Further, men sharing their lived experience of mental ill-health or stressful life events was seen as a powerful way to impart a message of courage, vulnerability and hope in the community. For example, prominent and respected sportsmen sharing their mental health stories can have a positive influence on men's help seeking behaviours through repositioning speaking out about mental health as a social norm (Harding & Fox, 2015). Building capacity for men to be able to step into positive leadership roles within the community and providing spaces that support sharing lived experience may help to promote healthier traits in men and normalize help-seeking.

Stakeholders saw a need to tailor program service and delivery to be sensitized to men's needs through the use of language and content. Health promotion messaging including labeling, advertising and content in community-based settings must be presented in ways that are accessible, easy to understand and sensitized to the specific needs of diverse audiences of men (Oliffe et al., 2019a). Within the content of programs, introducing mental health topics and language can help to reduce stigma by increasing men's understanding and literacy. However, as mentioned of concern by stakeholders, the associated stigma means that many men do not respond to language promoting 'mental health' or associated terms. Working within their language framework and avoiding pathologizing terms may assist in attendance and engagement, for example the Veteran Transition Program uses familiar language such as 'dropping

your baggage' and focusing on 'release' in counselling psychology programs with men (Cox et al., 2019). Further, care should be taken to avoid provocative language such as *toxic masculinity* that is likely to further disengage the population services are aiming to reach (VicHealth, 2020). Instead, stakeholders provided examples of positive framing which could be implemented, such as framing the vulnerability of help-seeking as courageous, although care should be taken to mitigate the risk of inadvertently reinforcing masculine norms through the assertion then that men who *don't* seek help are outside of the norm and are displaying weakness.

Leaning on men's sense of care for loved ones was viewed as a way to encourage caring for oneself. Elliott's (2016) theory of *caring masculinities* talks to this point; elucidating the benefit of reframing traditional masculine values of protector and provider into prosocial care-oriented values that exist within relationships without male dominance. Upholding caring masculinities by contributing to child care work and work in the home can have a suite of benefits for men's health including increased psychological wellbeing, longer life span, and improved intimate and nurturing relationships (Kimmel, 2010). The promotion of caring masculinities affords men with more flexibility in their masculine expression and may positively impact self-compassion and therefore comfort with help-seeking. In sum, health promotion efforts should seek to engage with men authentically, recognize the diverse influences of masculinities and provide opportunities for men in community to become positive role models and share their stories openly.

Implications

The findings presented here uniquely describe the characteristics of an inner regional community which diverges from both rural and metropolitan spaces both in terms of culture, and in structures and services available. As migration out of major cities into surrounding regional and rural areas continues, an understanding of place-based conceptualisations of masculinities and mental health is required in order to ensure that these populations of men are supported. Notably, the findings around belonging offer unique insights into how these inner regional communities can constrain men's social wellbeing, particularly in relation to the experiences of men who work away from their townships. With these additional challenges of geography and competing priorities in mind, the findings highlight the need to design community programs accordingly that understand and cater for these men's needs. Importantly, this research demonstrates that consultation with community stakeholders is a vital step in understanding the needs of men in a given community, and the capacity of that community to meet those needs in order to facilitate better translation from research into practice. By specifically outlining ways in which services and programs within a regional community can work to better engage with and support men, we hope to provide insights that can lead to concrete and practical implementation strategies for effective community wellbeing and suicide prevention programs.

Limitations and Future Directions

The present study has a number of limitations. First, the focus on stakeholder perspectives offers a third-party view into the challenges faced by local men and boys. While beneficial in its ability to draw from a diverse array of professional experiences and increase community engagement likely to enhance success of intervention implementation, future research into men's direct experiences within the local community is required. Further, we recognize that a study of local masculinities enrolled majority female participants, and as above recommend that future research aims to unpack masculinity from local men's personal perspectives. Female stakeholders' insights however provide valuable contribution to the study as they live and work with boys and men in the community, and therefore impact and are impacted by men's behaviours. Additionally, the specific concerns and needs of adolescent and younger men may not be well represented in the data due to the youngest participant being 33 years of age. We did not collect demographics other than age, gender identity and professional sector, limiting our ability to characterise and describe the sample. While interview schedules focused on questions related to professional opinions and experiences working with boys and men in the Macedon Ranges, it is likely that participant responses were influenced by their own personal preconceptions of and experiences with masculinity. Participants' (particularly male participants') own embodiment of masculinities are reflected throughout the findings, as they often switched between providing first person and third person narratives to explain their perspectives. There were varying levels of experience with or knowledge of masculinity and it's impacts on mental health dependent on the participant's sector and role. Some participants expressed that they had previously not put much thought into masculinity or 'what it means to be a man', while others actively worked to separate themselves from what they saw as dominant and harmful norms. The influence of participants personal ideas of masculinity should be taken into consideration when interpreting the findings. Stakeholders in this study were recruited through contacts of the Project Working Group. As such, the current sample may not be representative of stakeholder and service provider views more widely in the region. Having said that, participants worked across community sectors and were in contact with a diverse range of local men and boys in different facets. Given the relatively close proximity of the Macedon Ranges to the large urban center of Melbourne, results from the present study many not reflect views of stakeholders from more remote rural settings. Further, research should also seek to ensure the voices of rural and regional stakeholders from multicultural backgrounds are represented regarding to risk and protective factors for men's suicide.

CONCLUSION

The findings of this study describe stakeholder perspectives of the challenges for wellbeing faced by men in a regional community, and opportunities for intervention. Garnering stakeholder insights allowed for a diverse range of professional experiences within the research to inform better design, implementation and retention of future community-driven initiatives to support men and boys. Results indicated that community-based suicide prevention strategies must focus on increasing men's sense of belonging

within their communities by expanding the range of opportunities offered for healthy social interaction and also should promote a masculinity that allows for improved social connection and help-seeking for mental health problems when needed. Understanding the specific needs of men in an inner regional community that differs culturally and geographically from both urban and rural environments is a vital step towards reducing suicide and other harm-behaviours in men.

DATA AVAILABILITY STATEMENT

The datasets presented in this article are not readily available because of ethical restrictions. Requests to access the datasets should be directed to Simon Rice, simon.rice@orygen.org.au.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by The University of Melbourne Human Research Ethics Committee. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

KT completed data collection, data analysis and wrote the manuscript with support from SR. JO contributed to the research design, data analysis and final manuscript. DP, JR, GA, MW, ZS, CW, and KK contributed to the design of the research and the final manuscript. SR designed the research, contributed to data collection and analysis, and supervised all aspects of the research project. All authors contributed to and approved the final manuscript.

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The Potential Impact of Adjunct Digital Tools and Technology to Help Distressed and Suicidal Men: An Integrative Review

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Suicidal men feel the need to be self-reliant and that they cannot find another way out of relationship or socioeconomic issues. Suicide prevention is of crucial importance worldwide. The much higher rate of suicide in men engenders action. The prelude is a subjective experience that can be very isolating and severely distressing. Men may not realize a change in their thinking and behaviors, which makes it more difficult to seek and get help, thereby interrupting a "downward spiral". Stoicism often prevents men from admitting to their personal struggle. The lack of "quality" connections and "non-tailored" therapies has led to a high number of men "walking out" on traditional clinical approaches. But there are complicated relationships in motivations and formative behaviors of suicide with regards to emotional state, psychiatric disorders, interpersonal life events and suicidal behavior method selection. Middle-aged and older men have alternated as the most at-risk of suicide. There is no one solution that applies to all men, but digital tools may be of assistance (e.g., video conferences, social networks, telephone calls, and emails). Digital interventions require higher levels of effectiveness for distress and suicidality but self-guided approaches may be the most suitable for men especially where linked with an integrated online suicide prevention platform (e.g., quick response with online chats, phone calls, and emails). Furthermore, technology-enabled models of care offer promise to advance appropriate linking to mental health services through better and faster understanding of the specific needs of individuals (e.g., socio-cultural) and the type and level of suicidality experienced. Long-term evidence for suicidality and its evaluation may benefit from progressing human computer-interaction and providing impetus for an eminent integrated digital platform.

Keywords: high-risk and vulnerable men, suicide prevention, digital mental health interventions, digital tools and technology, self-help, human-computer interaction, technology-enabled care, integrated digital platform

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BACKGROUND

Suicide prevention is a primary global health concern. After a pattern of steady rise since the mid-2000s, suicide rates did not generally increase in the first months of the COVID-19 pandemic (Sinyor et al., 2021). However, more needs to be known about vulnerable populations and the effects of long-term economic and mental health stress (Sinyor et al., 2021). Prior to the current pandemic,

men were at a significant high-risk of suicide across all ages worldwide (1.5–10 times more prevalent than women) which called for the development of reliable knowledge for suicide preventive strategies to diagnose depressed and suicidal men (Sher, 2015; World Health Organization [WHO], 2021) as well as a better appreciation of this immense public health challenge (Sher, 2019). Pandemic-related stress (e.g., disease risk, ongoing economic uncertainty, loneliness, and lifestyle changes) have exacerbated men's high-risk for depression and suicidal ideation (Ellison et al., 2021). Lower prevalence rates of common mental health problems (i.e., anxiety and depression) in men should not be inferred that there is less overall experience of such (Gough et al., 2021). Instead, it was suggested that reporting of psychological symptoms is limited by hegemonic masculinities related to self-reliance and not expressing emotions. The preliminary validation of the Gender-Sensitive Depression Screening (Möller-Leimkühler and Mühleck, 2020) led to the proposal that the identification of atypical symptoms of depression may be useful for suicide prevention evaluations in forensic practice (Streb et al., 2021). Psychological screening analyses found non-reporting of affective symptoms as well as external behaviors (e.g., drinking alcohol or being aggressive to fit in with masculine norms and for masking or coping purposes) (Streb et al., 2021). In-roads are being made toward emotional intelligence in men. In-person activity-based initiatives (e.g., Men's Sheds) have brought together mainly older men to support each other whilst mental health support online offers promise in targeting communities of men (e.g., lifestyle and ethnic groups) (Gough et al., 2021).

Men increased their seeking of mental health care (at a higher rate than women for family and relationships) during COVID-19 (i.e., there was a 79% increase in virtual mental health care visits between January and September 2020) (Ellison et al., 2021). The current pandemic has contributed to the increased interest in and use of phones, computers, and other electronic devices for telehealth (Barnett et al., 2021) as well as technologies for the identification and treatment of mental ill-health across varied populations (Torous et al., 2020; Sorkin et al., 2021). Evidence of effectiveness for digital interventions was generally established for common disorders (i.e., anxiety and depression, particularly for adolescents and young people) (Lehtimaki et al., 2021). There is capacity for digital mental health to assist in serving the marginalized and underserved (Schueller et al., 2019) and effectively fill unmet needs for mental health care (Wind et al., 2020; The Lancet Digital Health, 2021). However, there are challenges with ethics, security, equity, user retention, and evaluation (Balcombe and De Leo, 2021a). Human support via paraprofessionals may increase the reliability and scalability of digital mental health interventions and help in overcoming user uptake, engagement, and dropout issues (especially in routine clinical settings) (Rosenberg et al., 2021).

A review of gender differences in the effectiveness of suicide prevention efforts found very few cases, none of which described digital mental health, and most were maximally beneficial to females (Hamilton and Klimes-Dougan, 2015). A systematic review and meta-analysis of randomized controlled trials (RCTs) found self-guided digital interventions are effective for directly targeting individuals' suicidal ideation (immediately after post-intervention) (Torok et al., 2020). An emerging indication of a late debut and ambiguous presentation of suicide-related communication in boys led to the suggestion for future research to explore online suicide-related communication and the potential for suicide prevention on digital platforms (Balt et al., 2021). To our knowledge, there is no literature specifically focusing on gender differences in the efficacy of digital assistance in suicide prevention. Therefore, theoretical and empirical samples of the literature were explored with the aim of appraising and synthesizing the potential impact of digital mental health tools and technologies to assist in the provision of faster and better service to distressed and suicidal men.

METHODS

This integrative review purposively sampled from Sage, ScienceDirect, Google Scholar, and CrossRef databases, reference lists of relevant reviews as well as three mental health websites and the WHO website. Search terms included: men, mental health, suicide prevention, digital mental health, digital tools, technology, digital interventions, digital phenotyping, telehealth, phone, email, internet, virtual reality, gender differences, human-computer interaction, and combinations of these terms. The authors independently assessed all abstracts against the inclusion and exclusion criteria according to the 5-step amendment (Balcombe and De Leo, 2021b; see **Table 1**) of a modified integrative review framework (Whittemore and Knafl, 2005). This methodology was applied to critically evaluate and synthesize the reported outcomes of empirical and theoretical literature converging "suicide in men" and "digital mental health" (i.e., with a focus on effectiveness, feasibility, accessibility, socio-cultural inclusion, rigor and readiness for adoption and upkeep in suicide prevention). The next section presents a summary of results followed by key concepts to provide clear and concise synthesis of the body of knowledge and recommendations.

SUMMARY OF MEN'S MENTAL HEALTH AND SUICIDALITY

Scientific research has yet to establish the underlying causes of suicide in men. More needs to be known about the complex relationship between mental ill-health, its comorbidities and the biopsychosocial factors that influence suicidality. Preliminary findings from Australian qualitative research with 35 suicide survivors described risk factors (i.e., disrupted mood, unhelpful stoic beliefs and values, avoidant coping strategies, and stressors) that led to suicidal behaviors; misinterpretation of changes in their thinking and behavior disabled identification of opportunities to interrupt suicide progression (a downward spiral) (Player et al., 2015). Furthermore, there was a lack of distraction, practical and emotional supports as well as the need for effective and tailored professional intervention (Player et al., 2015). Other Australian researchers have contributed quantitative evidence with their suggestions about male

TABLE 1 | Five step integrative review literature search method.

(1) Problem identification
(2) Literature search
• Participant characteristics
• Reported outcomes
• Empirical or theoretical approach
(3) Author views
• Clinical effectiveness
• User impact (feasibility/accessibility)
• Social and cultural impact
• Readiness for clinic or digital solutions adoption
• Critical appraisal and evaluation
(4) Determine rigor and contribution to data analysis
(5) Synthesis of important foundations or conclusions into an integrated summation

vulnerability and suicidal ideation: self-reliance stood out as a risk factor (Pirkis et al., 2016) in addition to family conflict, break-up of a relationship, difficulty finding a job, legal troubles, major loss of property and serious personal injury (Currier et al., 2016). An American perspective agreed on some aspects of suicidal behavior – the impact of socioeconomic issues and divorce but added parental alienation and pathophysiology issues – testosterone) (Sher, 2018).

There is a need to better understand and measure the motivations of those who die by suicide. A study that applied the Inventory of Motivations for Suicide Attempts established reliability for a two-factor structure – firstly for intrapersonal motivations related to ending emotional pain and secondly for interpersonal motivations related to communication or help-seeking (May and Klonsky, 2013). The former was associated with greater intent to die, while the latter was associated with less lethal intent and greater likelihood of rescue. Clinical relevance was proposed in a four-factor analytic study with a patient sample exhibiting high suicidality (Hayashi et al., 2017). Intrapersonal and interpersonal directedness classifications were used in support of the hypothesis that motivation for suicidal behavior is central to its development (Hayashi et al., 2017). A model provided understanding of the formative processes of suicidal behavior. Future studies were suggested to investigate the complicated relationships with emotional state, psychiatric disorders, interpersonal life events and suicidal behavior method selection.

Men have varied perceptions, expectations, attitudes, and behaviors with regards to mental health. Norms of masculinity associated with depression in the Australian cultural context focused on independence, invulnerability, avoidance of negative emotions, and stoicism (Rice et al., 2011) – the latter personality trait is also associated with suicide (Alston, 2012; Witte et al., 2012). The most at-risk for suicide age groups change over time (and vary between countries). In the previous decade, older men were reported to predominate suicide deaths in a global context – only clues were provided as to their vulnerability (e.g., rigid and traditional masculine sense of self and coping) (Canetto, 2017). An Australian psychological autopsy case-control study found older adults are more likely to seek professional help, receive treatment and express their hopelessness and suicidality before death (De Leo et al., 2013). A population-level ecological study observed geographic variability in suicide mortality analyses – older men who immigrated from North-West Europe to Australia and were dwelling as tenants were more represented in suicide mortality (Law et al., 2015). An Australian study of young males (aged between 18 and 30 years) with psychiatric problems found this group to be disinclined to seek professional help following a serious suicide attempt (Cleary, 2016).

Some males at-risk for suicide seek help but many do not get it (resulting in negative outcomes) – many received services that are not well-tailored to men (Pirkis et al., 2016; Milner et al., 2017). An Irish qualitative study noted the rate of suicide is highest among middle-aged men in many high-income countries but there is a lack of knowledge with regards to psychological distress and support-seeking among this cohort (O'Donnell and Richardson, 2020). A plurality of constraining themes emerged for middle-age masculinities and mental health experiences: perception of increased expectation countered by diminishing capacities to achieve, isolation, shame in having to ask for help and failing in their independence (as barriers to seeking help) (O'Donnell and Richardson, 2020).

Epidemiological studies are providing a pathway to understanding suicide in men. A longitudinal cross-sectional study of psychosocial job stressors in Australian men found an overall high prevalence – there was an elevated presence of suicidal ideation in those with low job control, job insecurity, and unfair pay (Milner et al., 2017). Engagement with mental health services is increasing for men in Australia but many of those at-risk of depression and suicidality are prematurely dropping out without informing their clinician because of a lack of progress/tailored treatments and connection with the therapist (Seidler et al., 2021). Gender norms are being investigated in trials with boys and young men in Australia, Canada, New Zealand, and the United Kingdom to determine the effect of mental health literacy programs (e.g., focused on helping a friend in sporting club settings) and facilitate positive attitude development toward help-seeking for mental health (Rice et al., 2021). There are aims to broaden equity via socio-cultural adaptability of the programs (two school-based interventions and one online intervention).

The mechanisms for understanding men's approach to mental health and suicidality was broadened by investigative insights from forensic screening, systemic review, sociological autopsy, qualitative, mixed method, and retrospective studies. A systematic review emphasized the opportunity to implement suicide prevention strategies during contact with primary health care – the average contact rate was 80% in the year prior to suicide and 44% in the final month before suicide (Stene-Larsen and Reneflot, 2017). However, screening and treatment of men's mental ill-health is complex. Men are more likely to manifest atypical behaviors (e.g., abusive, aggressive, risk-taking, or antisocial behavior) (Streb et al., 2021) and apply violent or lethal methods of suicidal behavior as an extenuation of difficulties from not recognizing or reporting depressive symptoms (Rutz and Rihmer, 2021). A systematic review with meta-analyses of observational studies in the United States found that firearms were used in more than half of suicide

attempts but there was inconclusive evidence that those with a diagnosis of a mental disorder were less likely of dying by suicide with a firearm (Zuriaga et al., 2021). Training for health care workers (Rutz and Rihmer, 2021) and screening tools for forensic psychiatrists (Streb et al., 2021) were suggestions for better detecting male depression and instilling broad awareness of how it atypically manifests.

A mixed methods study found older men from rural Australia had lower rates of diagnosis despite similar mental health rates (compared with women) (Fitzpatrick et al., 2021). The patterning of one's life course was found to be related to suicidality with regards to inequality and marginality, perceptions of culturally normative autonomy, and unmet needs within a social care system. A qualitative study with rural men in Canada noted a paradox of higher rates of suicide and substance abuse that coincide with lower levels of stress and depression (Herron et al., 2020). Most men desire to talk about their mental health but were challenged by relationships and places in which to do so. Hegemonic masculinity was reported as being mostly resisted. The hindering issues to men obtaining mental health treatment in the rural Australian context include stigma, lack of emotional expression, non-disclosure of distress, and barriers to seeking and getting help (Kennedy et al., 2020). A retrospective study of bereaved men's help-seeking before suicide found themes of complex relationships to seeking and getting help – there were those entrapped by secrecy and concealing the need for help, those with overwhelming illness that couldn't be helped, as well as those whom services and systems provided ineffectual help (Oliffe et al., 2020).

CURRENT STATE OF THE ART – DIGITAL TOOLS AND TECHNOLOGY

Digital tools (e.g., video conferences, social networks, virtual rooms, telephone calls, emails, audio conferences, online intervention platforms, smartphone/tablet apps, online forums, and chats), as well as predictive, immersive and wearable technologies are emerging as promising as an adjunct to mental health care and suicide prevention but also hindered by challenges in their adoption and sustainment (American Psychological Association [APA], 2021) especially for young people (Wies et al., 2021). Previously, digital suicide prevention was noted as involving the use of machine learning, smartphone apps, and wearable sensor driven systems (Vahabzadeh et al., 2016). But it is unclear how feasible and scalable digital tools and technologies may be effectively used for suicide prevention (with suitable specifications for men).

Data-Driven Identification and Intervention Approaches

Machine learning for suicide prediction emerged in a suicide risk algorithm study with US Army soldiers – 52.9% of posthospitalization suicides occurred after the 5% of hospitalizations with highest predicted suicide risk (Kessler et al., 2015). A pilot study applied an algorithm among patients with a mood disorder and identified suicide risk factors at the individual level by incorporating demographic and clinical variables (Passos et al., 2016). However, caution arose for recommending machine learning for suicide prediction (Chan et al., 2016; Mulder et al., 2016; Vahabzadeh et al., 2016). The clinical use of machine learning was noted as limited by an ongoing lack of information on model building and uncertain accuracy (Graham et al., 2019; Moon et al., 2019; Shatte et al., 2019) which contribute to potential ethical and legal issues (Balcombe and De Leo, 2021a; Schueller, 2021; Wies et al., 2021).

A natural language processing algorithm reliably identified risk for suicide and assisted telehealth clinicians to promptly respond with crisis resources (Bantilan et al., 2020). A lack of empirical evidence (Thieme et al., 2020) and a lack of efficacy evaluation in experimental and feasibility studies has challenged effective implementation of algorithms (Fonseka et al., 2019; Haines-Delmont et al., 2020; Roy et al., 2020). A commentary outlined that machine learning has outstanding potential, but it is constrained by insufficient data resulting in a lack of generalizability and sufficient comprehensiveness with regards to relevant variables (Lennon, 2020). The human-centered artificial intelligence (HAI) framework promotes ethically aligned design, human factors design and technology enhancement in a refocus on user-centered design processes (Xu, 2019) that have hindered human-computer interaction (Thieme et al., 2020).

Various population studies with machine learning algorithms have yet to be externally validated. A Swedish population study investigated national registry data of inpatient and outpatient visits with models trained for suicide attempt/death within 90 and 30 days following a visit (results were 3.5 and 1.7%, respectively) (Chen et al., 2020). A Danish population study found that machine learning may advance prediction of suicide (especially men with depression prescribed non-opioid analgesics, antipyretics, hypnotics, sedatives, and diagnosed with a poisoning) (Jiang et al., 2021). Two recent studies proposed advanced suicide prediction models (with machine learning methods that identify subgroups) in a significant prospective cohort study of the United States population (García de la Garza et al., 2021; Machado et al., 2021). A main difference between the studies is hypothesis-driven methods of the former study and data-driven approach of the latter study. This highlights a challenge of integrating machine learning algorithms with standard clinical care – the convergence of hypothesis-driven and data-driven methodologies is hindered by different evaluation approaches (i.e., traditional and modern) (Balcombe and De Leo, 2021a). For example, the agility of machine learning means it is redundant for a long series of RCTs (Shatte et al., 2019). A call was made for simulation-based approaches to assist end-users in expediting their evaluations (Guo et al., 2020).

Trials of technology-enabled models of care for Australian youth are seeking to demonstrate efficient and comprehensive coordination and delivery of mental health services (e.g., improving pathways to care and response to suicidal behaviors in a local system dynamics model) (Iorfino et al., 2021). An agent-based model and discrete-event model were applied for an individual-centric approach to seek appropriate services, follow a pathway and receive treatment. A simulation provides a

comparison of a "business as usual" approach and a technology-enabled care approach to assist in the evaluation of whether the "right" level of effectiveness is being delivered. Algorithms provide a fast and consistent response to risk by reducing "business as usual bottlenecks" via standardized digital pathways that determine appropriate care for those with high needs (Iorfino et al., 2021). The treatment frequency and reviews are determined by needs – suitable intervention targets are set by the model then it reviews targets over time to inform better care decisions. This online multi-dimensional assessment and triage is a personalized model of care that assists clinicians early in the intake to accelerate an automated process (and in effect reducing duplication).

Machine learning (including deep learning) has been proposed as promising for easing the understanding of mental health (between the patient, mental health care practitioner and the machine) (Barredo Arrieta et al., 2020). A proof-of-concept prototype development for an early intervention study suggested application of explainable artificial intelligence (XAI) by combining common sense knowledge with semantic reasoning and causality models (Ammar and Shaban-Nejad, 2020). However, the temporality of suicide means there is a risk of machine learning becoming outdated because of a lack of specificity for data points from registries, electronic health records or other databases (Lennon, 2020). There is emerging evidence using radiography or online data methods. A cross-sectional assessment of structural Magnetic Resonance Imaging (MRI) data with a support vector machine learning model for a sample of adolescents/young adults diagnosed with major depression disorder found a high-level of accuracy for predicting those with suicide ideation and/or attempts (Hong et al., 2021). A transformer-based deep learning model sought suicide risk identification from social media sources – it was proposed as effective for classifying suicide notes (i.e., contextual and long-term dependency information determined from different datasets) (Zhang et al., 2021). Machine learning helps analyze big data easier by automating processes – this helps support a better predictive potential of an individual's suicide risk but there is yet to be accurate prediction of specific risks across populations.

Internet and Related Technologies

The most common digital tools used for self-help are accessed online via digital platforms and apps. Guided approaches are delivered in web chat and peer support forums as well as by phone (e.g., calls or texts) to provide crisis support, psychotherapy, counseling, psychological treatments, as well as support for recovery. Health promotion, education, and mental ill-health/suicide prevention are available in self-help or guided approaches.

The evidence synthesis on self-help suggests a suitability for suicidal men in quickly helping themselves and getting linked to unobtrusive services and support when needed. A RCT found that web-based self-help can be effective in reducing suicidal ideation and serves well as an adjunct to regular care (57% of participants were receiving additional help) – embedding the intervention in an integrated online suicide prevention platform helps to provide human support by email or a quick referral to more intensive care if required (Van Spijker et al., 2014). Three RCTs with a brief, mobile intervention (a game-like app) found promising reductions in suicidality with note of a potential to have a large-scale impact (Franklin et al., 2016). A systematic review concluded self-guided digital interventions for suicide prevention are effective (at least in the short-term), should be promoted and integrated into health systems in countries where it has been tested (Torok et al., 2020). But there needs to be population studies, alleviation of safety concerns as well as further studies for non-CBT approaches being possibly more effective (Torok et al., 2020).

Head to Health is an Australian digital platform bringing together more than 700 trusted mental health services (i.e., apps, online programs, online forums, and phone services, as well as a range of digital information resources). It is noted as effective for people with or at risk of mild to moderate mental health difficulties. There are 41 resources for suicide prevention (two apps, two forums, six phone call links, five web chat links, two email links, one SMS link, one video call link, 19 websites, and three information resources on suicidal thoughts and finding support, crisis links as well as information for parents). There are no known studies that have explored the demographics of Head to Health (or other integrative digital platform) users or the efficacy and impact of its use. A RCT evaluated the usability of the Thought Spot digital platform – a high attrition rate was noted with only 20% of mental health services or resources viewed by end users (Shi et al., 2021). Connection and engagement in a therapeutic alliance is important in using digital platforms (Arshad et al., 2019). Although the overall effect size of suicide prevention digital interventions is minor, there is an opportunity to explore the population impact if promoted though internet and digital distribution platforms (e.g., it is possible through app stores) (Torok et al., 2020). A qualitative study focused on virtual coaches for CBT noted engagement difficulties hindering the effectiveness of using digital platforms (Venning et al., 2021). Guided approaches for suicide prevention are useful if carefully administered and delivered but require more efficacy. Telehealth use in primary care (i.e., a suicide prevention hotline) appeared to have temporal efficacy (Rhee et al., 2005). A clinical trial found telepractice to be as feasible as traditional in-office clinical care delivery if there is accordance with safety plans, training, and published guidelines (Luxton et al., 2014). Telehealth was deemed as useful in continued psychiatric care during the COVID-19 pandemic especially for postvention (Rothman and Sher, 2021). A systematic review and random-effects meta-analyses of brief contact interventions (letter, postcard, telephone, green card or crisis card) for reducing self-harm, suicide attempt, and suicide recommended well-designed trials in clinical populations (Milner et al., 2015). A RCT involving caring emails intended on preventing suicide behaviors among United States service members and veterans (Luxton et al., 2019) also did not draw firm conclusions on efficacy but no adverse effects were associated with the intervention.

Qualitative research has been applied in mixed self-help and guided approaches for a mental health promotion context highlighting the potential of a positive impact through novel, media-based public health interventions. A trial involved

an online survey that measured the impact of the Man Up documentary, an Australian media-based public health intervention that explored the relationship between stoic masculinity, mental health and suicide - key messages included being prepared to help others and being more emotionally expressive (King et al., 2018). Testing of the promotional materials and website for the Man Up program found active and empowering language to be potentially useful for informing men's mental health promotion interventions (Schlichthorst et al., 2019).

Digital Interventions and Technologies

Digital interventions for suicide prevention include automated CBT, digital speech analysis, facial emotion analysis, smartphone/mobile apps, wearable sensors and cloud-based technology (Vahabzadeh et al., 2016; Rege, 2020) as well as a possibly more effective combination of dialectic behavior therapy, CBT for insomnia, and therapeutic evaluative conditioning (Torok et al., 2020). Mobile/smartphone apps have a large share of the technology market but there are issues with the privacy of personal data, and the need for clinical guidance and education about the lack of evidence (Torous et al., 2018).

Although technologies are rapidly advancing, empirical evidence for digital interventions is lagging. A rapid meta-review found digital interventions are well-disposed to mitigate mental ill-health at the population level with good evidence on usability, safety, acceptance, satisfaction, and effectiveness (Rauschenberg et al., 2021). But there are limited guidelines on interventions for patients who identify as high risk of suicide on digital platforms (Bai et al., 2020; Bailey et al., 2020). A systematic review found social media platforms, e-learning content, online resources and mobile apps were developed to deliver digital interventions during COVID-19 but were limited by a low level of empirical evaluation, challenges in adoption as well as a need for greater heterogeneity (Drissi et al., 2021). A systematic review of digital interventions for indigenous people found an overall acceptability of an array of digital technologies with promising measurable outcomes to help address high rates of suicide, depression, and substance abuse (Li and Brar, 2021). A comprehensive review of digital interventions for suicide prevention found a great potential to advance the response to suicide risk but standalone digital interventions are likely insufficient because apps or media present a single suicide prevention strategy (lacking integration with others on a platform) (Braciszewski, 2021).

A narrative review of multiple RCTs and a large meta-analysis of the effectiveness of digital psychotherapy found good evidence for depression and anxiety disorders of mild-to-moderate severity (Weightman, 2020). But the evidence of effectiveness for other digital interventions is not as clear. Togetherall (previously Big White Wall) is a global online mental health support community (peer-to-peer approach moderated by clinical professionals). It was the subject of a fully automated RCT which sought to test the clinical effectiveness of the online peer-support program versus web-based information for self-management of anxiety and depression (Morriss et al., 2021). However, there was insufficient recruitment and retention of participants – a personal approach to participant engagement was recommended. Controlled studies are required to increase the effectiveness of CBT in reducing suicidal ideation (Büscher et al., 2020) but it is the most used digital intervention (Van Doorn et al., 2021).

A systematic review found digital interventions and technologies used in counseling are as effective as face-to-face sessions (De Bitencourt Machado et al., 2016). Quality assurance for digital interventions was proposed as applicable to the existing arrangements with governing agencies or professional associations (Dores et al., 2018). An online survey of the use of digital technologies in psychological counseling before and during a COVID-19 lockdown noted a slight rise in the use of video conferences, social networks and virtual rooms but slightly less use of telephone calls, emails, audio conferences, online intervention platforms, smartphone/tablet apps, online forums, and chats (Dores et al., 2020).

A case series on young adults with a psychotic illness found digital phenotyping via tracking on a smartphone app is a feasible way to monitor and detect patient status as opposed to an intervention (Wisniewski et al., 2019). Limited by individualized evidence, population studies were recommended to increase the potential for digital phenotyping to monitor in real time for safety (e.g., risk of suicide) (Wisniewski et al., 2019). Digital phenotyping of passive data from smartphone and wearables in addition to questionnaires could potentially measure the suicidal ideation process through ecological momentary assessment (Braciszewski, 2021). Rather than focus on the empirical value of digital phenotyping, an analysis found a good potential on practical, efficient, convenient, and non-intrusive information acquisition about holistic health as well as a potential to provide valuable insights related to the various factors that constitute a diagnosis, state or condition (Coghlan and D'Alfonso, 2021).

Immersive Technologies

Virtual reality (VR) was applied in experiments to test ideas about the causes of suicide – males were more likely to have VR suicide completion, but the translational approach was noted as an approximation of actual suicide which largely limits its ecological validity and makes it only tentatively useful (rather than replicable) for future studies to gain knowledge about suicide (Franklin et al., 2019). Subsequent research has mainly focused on the mental health implications of youth using VR and video games. A systematic review of a small number of available digital interventions for common disorders and phobias in children and young people via video games and VR found evidence of efficacy but noted the need for co-design, development, and evaluation before they are used in treatment (Halldorsson et al., 2021). A longitudinal approach to development and design, and greater heterogeneity are required for studies evaluating immersive digital interventions for children (Davies and Bergin, 2021). A systematic review of the use of commercial off-the-shelf video games (i.e., exergames, casual video games, action games, action-adventure games, and augmented reality games used in

consoles, PCs, smartphones, mobile consoles, and VR systems) suggested there is effectiveness in reducing stress and anxiety (Pallavicini et al., 2021).

HIGHLIGHT OF FUTURE DIRECTIONS

Future studies for suicide prevention in men should investigate the efficacy of self-help approaches as a core issue and explore the potential of branching out the ecosystem with adjunct digital tools and technology including the validation of machine learning algorithms in different populations, the development and use of high quality and high impact integrated digital platforms as well as optimization of technology-enabled care coordination (e.g., automated personalized model of care to link patients efficiently and effectively with appropriate mental health care services).

KEY CONCEPTS

Suicide continues to contribute to a globally significant socio-economic burden. Suicidality is exemplified in men of all ages, notably during middle-age but older men have also represented the highest risk. Although mental ill-health is a significant risk factor, its accurate prevalence is unclear as many men are not intervened because of their self-reliance and stoicism as well as ineffective mental health care treatments (complicated by atypical behaviors and manifestations of depression). There have been promising signs of improvements with men engaging in mental health care services and promotion interventions but accurately predicting and intervening their suicidal behavior has complexities and challenges. The potential of applying machine learning to population datasets to predict suicidal behavior remains unknown. Automation has led to advances of efficacy at the individual level but engagement with subjective experiences remains crucial for mental health care practitioners. Digital tools and online resources are available for self-help or guided approaches via digital platforms and apps, web chat, peer support forums, email and/or phone as well as digital interventions (e.g., mainly CBT but also digital phenotyping as well as VR and video games).

The evidence synthesis found higher levels of efficacy and evaluation are required before recommending digital interventions for distress and suicidality. But there is a good potential for self-guided digital interventions to serve as an adjunct especially with men (who may often find it difficult to get satisfactory help and can be complex and difficult to serve). It is unclear what to prescribe for digital suicide prevention because of a lack of strategy integration for apps or media – there is potential for better human-computer interaction (e.g., promoting suicide prevention apps on internet and digital distribution platforms). Well-designed and developed multi-modal digital platforms may help to advance evaluation of online resources for suicide prevention, stimulate evidence for long-term suicidal behavior prediction and optimal interventions as well as serve as a hub for self-help, digital interventions and technology-enabled care coordination.

AUTHOR CONTRIBUTIONS

LB contributed to the planning, conduct, and reporting. DD contributed to its review. LB and DD contributed to the final article and approved the submitted version of the manuscript.

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Uncovering Historical Legacies to Contextualize Health Inequities in Puerto Rican Men: An Expansion of the Minority Stress Model

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Background: Low/no-income Latino men are disproportionately burdened by chronic disease morbidity and mortality, which is often compounded by persistent exposure to stress. Chronic stress is a key mediating factor in pathways linking macro-level socio-structural forces to micro-level behavioral factors with negative health outcomes. Being that Latinxs continue to be one of the fastest growing populations in the U.S., it is imperative to better understand the roots of stress pathways and explore multi-level interventions.

Methods: This study presents qualitative findings from in-depth interviews with Puerto Rican men (95%) living in Springfield, Massachusetts. We utilized the Minority Stress Model (MSM) first posited by Ilan Meyers, as a framework to understand stress and stress processes amongst Puerto Rican men. We mapped our data onto Meyers' MSM, which allowed us to find diverging themes and identify areas for expansion.

Results: As expected, participants reported stress rooted in experiences of racism and prejudice, expectations of rejection, English-language acquisition, family relationships, insecure housing, precarious employment, and lack of resources. Nevertheless, the MSM did not account for the historical contexts that, as our findings indicate, are used to filter and understand their experiences with everyday stressors. Participants described and linked histories of colonial violence and movement and migration to their stress and community wellbeing.

Discussion: Findings suggest the need to expand the current MSM and our conceptualization of the stress process to include historical understandings when contextualizing present-day stress and future interventions. We propose an expanded heuristic model that delineates the impact of distinctive historical trajectories that aid in interpreting racial health disparities amongst minoritized populations. Future multi-level interventions should give weight to highlighting history and how this impacts the present, in this case including the culpability of U.S. policy regarding Puerto Rico and the adverse health effects for Puerto Rican men on the mainland.

Keywords: Latino health, men's health, minority stress, health inequity, thematic analysis

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INTRODUCTION

Low/no-income Latino men are disproportionately burdened by chronic disease morbidity and mortality compared to their non-Latinx White counterparts (Freiden et al., 2011; Heron, 2018; National Center for Health Statistics Health United States, 2018). A pressing consideration exacerbating these disparate rates is the emerging data showing Latinxs are at higher risk of hospitalization or death from COVID-19 than other racial and ethnic groups in the U.S. (Centers for Disease Control Prevention, 2020; Sáenz and Garcia, 2021). Higher rates of chronic disease experienced by Latino men are often compounded by persistent exposure to stress (Sternthal et al., 2011; Krieger, 2014). While not all exposure to stress is harmful, a robust body of literature suggests strong associations between chronic stress and poor behavioral, emotional, and physical wellbeing (Stenström et al., 1993; Rosengren et al., 2004; Segerstrom and Miller, 2004; Moreno-Smith et al., 2010). Based on our ongoing research with low/no-income Latino men, we see chronic stress as a key mediating factor in pathways that link macro-level socio-structural forces (i.e., institutional racism, unemployment, and housing insecurity) to micro-level behavioral factors (i.e., detrimental nutrition, sedentarism, substance use, and violence), with negative health outcomes (i.e., diabetes, stroke, liver disease, and psychological distress) (Buchanan et al., 2018; Valdez et al., 2021).

The pathways by which stressful experiences transcend into inequitable health outcomes for Latino men are poorly understood and understudied. Given that Latinxs continue to be one of the fastest growing populations in the U.S., expected to make up 25% of the population by 2050 (U.S. Census Bureau Population Division, 2018), it is imperative to better understand stress pathways and coping mechanisms to inform stress and chronic disease prevention efforts with this community. Utilizing and expanding upon the Minority Stress Model (MSM) developed by Meyer (1995, 2003) as an analytical framework, this article uses qualitative data from 40 in-depth interviews with Puerto Rican men to deepen our ability to understand and intervene upon the etiological pathways of stress and stress processing that is uniquely experienced by this subset of Latino men.

While understandings differ across disciplines, for the purposes of our work, we operationalize *stress* as the *"the process in which environmental demands tax or exceed the adaptive capacity of an organism, resulting in psychological and biological changes that may place persons at risk for disease"* (Cohen et al., 1995). That is, stress-inducing exposures can include routine environmental pressures related to family or work, significant life changes, traumatic events, social isolation, exposure to violence or natural disasters, as well as lived and vicarious experiences with racism and discrimination (Valdez et al., 2021). A recent review suggests that experiences with discrimination are associated with alterations in hypothalamic-pituitary-adrenal (HPA) axis activity; timing and duration of discrimination experiences may be central to understanding how this leads to HPA dysregulation resulting in stress-related disease (Agorastos and Chrousos, 2021). Persistent psychosocial stress related to discrimination also has been associated with elevated systolic blood pressure, increased body fat, and higher fasting blood glucose levels (Williams et al., 2003; De Vogli et al., 2007), effects that may differ by gender for Latinxs (McClure et al., 2010). Fear of persecution due to immigration authorization status, exposure to unjust policing practices in minority communities, being denied employment or housing, and receiving inadequate education or medical services can lead to stress for Latinxs (Finch et al., 2000; Berk and Schur, 2001; Pérez et al., 2008; Araújo Dawson and Panchanadeswaran, 2010). Inclusively, social isolation-related psychological distress often compounds stressful situations that Latinxs find themselves in, particularly when considering migrant Latinx populations (Negi, 2013). Social isolation among migrant Latino men has been associated with higher depressive symptoms, as well as drug-involved accidental death (Mora et al., 2014).

Research shows Puerto Ricans, generally speaking, experience higher rates of psychiatric disorders and poor physical health in comparison to other subgroups of Latinxs (Alegría et al., 2007; Wassertheil-Smoller et al., 2014; Woo et al., 2020). For instance, findings from the Hispanic Community Health Study ($N = 15{,}830$) suggest that Puerto Rican men, specifically, had the highest mean allostatic load in the sample, which increased with age (Salazar et al., 2016). Accordingly, findings from the National Latino and Asian American Study suggest that Puerto Rican Latino men experience the highest rates in 8 of 15 stress-related physical ailments, including heart disease, hypertension, and overweight and obesity, compared to their Non-Latinx White counterparts and other subgroups of Latino/a men and women (Ai et al., 2013).

Research also indicates that movement and migration, whether from island to mainland or state to state within the mainland, is associated with increased psychological distress and poor physical health for Puerto Rican Latinxs (Diaz, 1998; Aranda, 2007; Gonzalez et al., 2021). "Colonial migration", as McGreevey (2018) names it, has been and continues to be an integral part of Puerto Rican life. Colonial migration is undertaken for survival: U.S. colonial policies in Puerto Rico result in political, social, and economic upheaval and drive Puerto Ricans to search for higher wages, education, and access to social services (Vasey and Manderson, 2010; Lueck and Wilson, 2011; Gonzalez et al., 2021). Major shifts in migration toward the continental U.S. and the formation of the Puerto Rican diaspora began shortly after World War II, as U.S. industrialization spread into Puerto Rico under "La Operación Manos a la Obra", (Operation Bootstrap), beginning in 1947 (Santana, 1998). The policy included tax exemptions for U.S. corporations to set up factories on the island, with the provision of a cheap labor force and under the premise of "building a modern, developed nation" (Santana, 1998, p. 93). Imperialist policies shifted the economy from agriculturally-based to primarily export manufacturing. This shift led to rural dislocation, family disruption, quelling of independence movements, increased economic dependency on the U.S. and forced reliance on imports, and the drive of migration North

in hopes of a better life (Silén, 1971; Santana, 1998; González, 2011).

Although this migration as a result of Operation Bootstrap was known as the "Great Puerto Rican Migration" (1950–1960), the years from 2006 to 2017 saw the largest Puerto Rican migration to the mainland in history, with ∼54,000 Puerto Ricans migrating annually (Gonzalez et al., 2021). Economic actions by the U.S. (supported by Puerto Rican officials) continued to devastate Puerto Rico, leading to an increase in the island's public sector debt and enhanced austerity measures. Poverty, unemployment, and food insecurity rates all saw major increases, along with crumbling infrastructure, increases in crime, and hollowing out of any social safety nets (Gonzalez et al., 2021). More recently, Hurricane Maria and a series of earthquakes have devastated the island, driving more current migration from the island to the mainland. Furthermore, movement within the U.S. also stems from disinvestment within communities and higher costs of living, leading Puerto Ricans on the mainland in search of better opportunities in other states (Krause and Gubrium, 2019). Currently, the ongoing pandemic has deepened the already crisis-laden economy and it is predicted that 300,000 Puerto Ricans will migrate to the U.S. mainland between 2020 and 2022 (Segarra, 2020). The center holding piece of Puerto Rican migration was and continues to be rooted in U.S. colonialism—the proliferation of destabilizing pre-migration conditions in Puerto Rico is intimately linked to the accumulation of U.S. profits and geo-political power. On the individual level, the ongoing colonial status of Puerto Rico has and continues to have a disastrous and chronic effect on the mental health of Puerto Ricans (González, 2011).

In an effort to better understand the etiological pathways of stress and stress processing uniquely experienced by Puerto Rican men within our study, we reference the MSM originally posited by Meyer (1995, 2003). The MSM is a heuristic framework that elucidates the potential pathways that lead from chronic stress exposures and health outcomes in vulnerable groups. The MSM, developed by Meyers, is frequently used to explain heightened psychological distress and greater risks of suicidality in gay, lesbian, and bisexual populations (for example: Flenar et al., 2017; Kramer et al., 2017; Avery-Desmarais et al., 2020). The core concept of the MSM establishes why stigmatized and marginalized populations experience disproportionately higher rates of chronic stress and related adverse health effects due to their social "minority" status. Stress stems largely from internalized marginalization, perceived stigma, and actual events of discrimination and violence (Meyer, 1995). The model includes both proximal and distal influences to illuminate the processes of stress within a marginalized population, while helping to visualize both the myriad stress-related circumstances in a particular population's experience and protective factors that reduce stress. Further, the MSM includes such variables as environmental circumstances, mental health outcomes, general life stressors such as marital disputes or finances, identity characteristics specific to marginalized groups, and coping and social support mechanisms to combat stress.

Although often used for health intervention measures aimed at the LGBTQ community, the MSM has since been utilized to examine and explain chronic stress and adverse health in other marginalized populations, as originally envisioned by Meyers. For example, the MSM model has been used in studies examining the experience of autistic individuals struggling with mental health (Botha and Frost, 2020), stress and isolation in Latino day laborers (Negi, 2013), and stress and food-related practices within immigrant populations (Berge et al., 2018). Applying the MSM to historically marginalized social groups (as in these examples) is useful for locating the multi-level manifestations of stress for a particular "minority identity", providing descriptions of environmental factors and institutional discrimination, as well as discovering protective factors.

Meyers argues for the need for multi-level interventions. "The stress model", (Meyer, 2003) contends, "can point to both distal and proximal causes of distress and to directing relevant interventions at both the individual and structural levels" (p. 692). Overall, the model posits that stress can be conceptualized as subjective (individual) and objective (structural) (Meyer, 2003). The subjective view considers how an individual copes with stress and personalized experiences, such as internalized stigmatization or being the recipient of a discriminatory act; the objective view pays attention to the stress-inducing environmental factors, like pollution or crumbling infrastructure, that force an individual to adapt and are present regardless of individual reaction. (Meyer, 2003) considers the assumptions that have long been made about minority stress by researchers, namely, that minority stress is: (1) unique (added stress based on marginalization); (2) chronic (reoccurring); and (3) socially based. Socially based relate to the "objective view" that stress is created due to "social processes, institutions, and structures" (i.e., discrimination within courts, educational systems, and housing policies). Here, however, is where Meyers' model falls short, particularly when considering structural or "objective" circumstances. Absent is recognition of the historically-based circumstances of one's life that could help explain discrimination-based stress and maintenance of the status quo, for any minoritized population. Krieger (2014) writes that discrimination at its core is "a historically entrenched cross-generational societal phenomenon, one that creates and preserves privilege for dominant groups at the expense of subordinated groups. After all, if discrimination served no function, it would presumably be simple to eliminate" (p. 687). The MSM—as it is—can illuminate the privileges that dominant groups possess, because the model enables the parsing out of society's institutions and their impact on marginalized identities. However, it overlooks the "historically entrenched" component that Krieger gives a nod to.

This article discusses how the MSM can be expanded to include historical legacies and then utilized to examine stress-related health disparities of minoritized populations. We propose an expanded heuristic model that delineates the impact of distinctive historical trajectories that aid in interpreting racial health disparities amongst minoritized populations. Importantly, the objective of this work is not to critique the shortcomings of the MSM but to expand upon its carefully constructed architecture to add dimensions that could amplify its utility with other minoritized populations. The intended use of our model is

not only to better understand the etiology of disparities in disease outcomes, but also to provide a pathway toward developing improved responsive multilevel intervention efforts with Puerto Rican men.

While the terms Latino and Hispanic are often used interchangeably to describe people of *any race* with cultural ties to Latin America, we have chosen to use Latino (and the variant Latinx) as it is the most widely recognized within the communities where the current work took place. The term Latinx (plural Latinxs) is a neologism used to describe people of Latin American ancestry in a gender-inclusive manner (María del Río-González, 2021). For the purposes of our work, when referring to a community as a whole where the gender of a collective is unknown, we use *Latinx*. When referring to subgroups in which self-reported gender is present we use *Latino* or *Latina*.

METHODS

The Men of Color Health Awareness (MOCHA) program is a community driven effort started in 2012 in Springfield, MA. While MOCHA's approach has evolved throughout the years since its inception, in its latest rendition, MOCHA has brought together cohorts of low/no-income, mostly African American men, with an aim to improve health through participation in a 10-week program to decrease stress and chronic disease vulnerability. MOCHA does this through an integrated model that addresses physical, mental, and spiritual health, while also emphasizing social connectedness and understanding of stress rooted in experiences with poverty and class discrimination and racism, and gender role strain (Valdez et al., 2021). The data used in this study were collected as part of a formative effort to improve the cultural responsiveness of the MOCHA curriculum for Latino men in the greater Springfield, MA area.

Study Setting

All data collection occurred in non-clinical community locations in the greater Springfield, MA metropolitan area between October 2019 and January 2020. This area struggles with the effects of deindustrialization and a precarious economy, which has a disproportionate effect on the socioeconomic survival of its most vulnerable citizens (Mullany et al., 2021). To date, Latinxs comprise ∼49% of the Springfield, MA metro area (City Data, 2019), which is the largest population of Puerto Ricans per capita on the mainland U.S (Granberry and Mattos, 2019). Latinxs comprise 28% of those living below the poverty level, over double that of the non-Latinx White population (City Data, 2019). Latinxs in the area experience the compounded effects of economic and educational disinvestment, high unemployment rates, persistent racial segregation, lack of access to adequate housing and transportation, environmental exposures, food insecurity, and lack of political representation. As a result, Latinxs living in the Springfield metro area are disproportionately burdened with health inequities (Cortés and Vega, 2010).

Recruitment and Participants

Active recruitment took place *via* project-based tabling at community agencies, local employers, and other relevant community events coordinated by a Latinx bi-cultural, bi-lingual, male-identified MOCHA mentor (i.e., graduate of the MOCHA program). Men were eligible to participate if they: (1) self-identified as a Latino/x, Hispanic, or bi-ethnoracial-including-Latino man; (2) aged between 25–64 years; (3) self-defined insufficient or low/no-income; and (4) lived in the Springfield area for the previous 6 months. A total of 48 men were scheduled for interviews, and 40 of those men completed interviews and sociodemographic questionnaires.

All but three of the participants were of Puerto Rican origin. The average age of participating men was 57.5 years. Approximately 30% of the men were married or lived with a spouse, 55% did not obtain a high school diploma (or equivalent), and 90% men reported <$29,999 in annual income. Over half (55%) of the participants spoke only Spanish, and 72.5% were born in Puerto Rico. All study procedures were approved by the University of Massachusetts Amherst Institutional Review Board.

Data Collection and Analysis

A research team member (LAV) trained in community-engaged qualitative data collection carefully explained all study procedures to participants and provided space and time for questions and needed clarifications. The semi-structured, in-depth interview protocol was based on questions used in inquiry conducted by the research team in formative work for previous renditions of the MOCHA curriculum and elicited the examination of: (1) definitions of health, (2) manhood/masculinity and being Latino/x, (3) perceptions of stressors and coping mechanisms for Latinxs, and (4) perceptions of the fairness or justice of health disparities. Nevertheless, the majority of relevant data used in this analysis emerged from discussions of *stressors and coping*. The interview protocol included questions such as "What does 'being healthy' mean to you," "Tell me a little bit about what you learned, while growing up, about how to be a man," and "Thinking back over the last week or two, what sorts of stresses (if any) did you experience?" Participants were carefully informed of all study protocols, as well as the risks and benefits of their participation, and were given ample time and space to ask questions before their written and verbal consent were obtained. Recorded interviews lasted anywhere from 60 to 90 min and were followed by a sociodemographic questionnaire. Participants received $25 for their participation in the study.

Digital recordings of each interview were transcribed verbatim. Interviews that were conducted in Spanish were translated into English to facilitate analysis, which included a back translation process to ensure the validity of the translation and to limit potential loss of meaning. Because the primary purpose of the current study was to better understand stress and the stress process of Latino men, we used the Minority Stress Model (Meyer, 2003), first as a heuristic device for mapping our data, and then as a guide for our coding process. We used a hybrid thematic analysis approach (Fereday and Muir-Cochrane, 2006) to facilitate the use of a priori themes based on the objectives of our work, as well as the identification of themes that emerged throughout our analysis. Two (LAV, AM) members of the research team trained in qualitative data

analysis reviewed the transcripts for accuracy and developed an initial codebook. Thereafter, three (AM, SS, MB) members of the research team conducted iterative reading and preliminary coding of four transcripts and came together to settle any coding disagreements. Coded transcripts also were spot-checked by one member of the research team (LAV) to ensure reliability of coding and to account for analytic drift. Theme saturation was derived from the diminished variation in coded transcripts. NVivo 13 (QSR International) was used to facilitate data organization and management.

RESULTS

The MSM assisted in identifying both structural correlates and more individualized psychological stress processes and patterns, adverse mental and physical health outcomes, and coping mechanisms; all these variables were understood and linked to the men's "minority status" of being Puerto Rican. We found, however, that in mapping our data, there was a gap in the MSM that did not historicize the men's lives and make visible the life histories and trajectories that contribute to and contextualize current stressors. Most notably, interspersed throughout the interviews the men reflected on both the colonial status of Puerto Rico and their lived experiences with movement and migration. In the first part of our results, we illustrate our utilization of the MSM (**Figure 1**, 2003) in parsing out the data to show the stress processes of marginality and coping. In the second part of our results, we use brief excerpts from our interviews to illustrate the need to expand the model to include consideration of historical contexts of stress for Latino men. **Figure 1** is an adaptation of the Minority Stress Model based on that originally posited by Meyer (2003) and includes how our data from Latino men map onto the original elements of the MSM along with our addition of the historical context.

Mapping Onto the MSM

Surviving at the Margins

In congruence with existing minority stress models (Meyer, 2003), stressors and the stress process reported by the men in our sample were *uniquely* experienced by them (not experienced by non-stigmatized populations), *chronic* (repetitive over a long time), and *socially based* (amplified by social process, institutions, and structures). As expected, iterative analyses of this data suggested that, to a large extent, the men in our sample reported stress rooted in experiences of racism and prejudice, expectations of rejection, English-language acquisition, family relationships, insecure housing, precarious employment, and lack of resources. Direct mapping onto the MSM facilitated a clear visualizing of the stress processes for these men. For instance, in terms of (*b/e) the minority status and identity,* the participants were keenly aware that the stressors they experienced were due to the intersection of their identities as Puerto Rican, as men, their marginalized socioeconomic status, and for some, previous experiences with the criminal justice system, all of which resulted in exacerbated social marginalization. The men in our sample reported that some of their most concerning stressors were related to direct and vicarious experiences with prejudice and discrimination due to their physical features (e.g., skin tone and hair), their nativity, and their English language acquisition. Importantly, men in our sample, largely U.S. citizens, reported having been victims of direct discrimination due to the compounded effect of being believed to be undocumented at a moment in time when the political discourse was fervently scapegoating and vilifying undocumented Latinx im/migrants.

Many of the men discussed *(a) environmental factors* that induce stress, such as gang activity in their neighborhood, lack of community resources, precarious employment, and/or substandard housing. Men also were keenly aware of their *(b) minoritized statu*s and the MSM helped to plot out the men's intersected *(c) general* life stressors, such as troubled finances, dealing with death, and marital strain. For example, participants recalled that many of their stressors are linked to their ability to provide for themselves and their families. Men also reported that this stress often is compounded due to their perceived lack of sustainable employment opportunities, citing that most of the work available to them pays little, is often strenuous and dangerous labor, or is temporary or precarious. Men discussed *(d) distal*-induced stress that stems from racialized interactions embedded within institutions, such as policing, a disinvested education system that yields poor educational opportunities and outcomes, and housing and employment discrimination. And finally, analysis of our data based on the MSM illustrated clearly how direct racist stigmatization toward Latinx im/migrants (distinctly Black and Brown migrants) plays out in both internalized and external ways; these (*f*) *proximal stressors* included chronic individual experiences with race- and ethnicity-based discrimination, intra-group disunity, self-stigmatization, and internalized expectations of failure.

Social Connectedness and Ameliorative Coping

Importantly, the MSM also highlights coping mechanisms and supports bound to participants' minority status as Latino men that buffer stress. The creation and nurturing of social connectedness, centered in familial ties and otherwise, was highlighted as an imperative factor in *(h) coping and social support* for participants. Specifically, the men in our sample reported how culturally significant family relationships, positive interpersonal relationships with others, and overall community support were integral to buffering the impact of daily and chronic stress. For instance, characteristics of family relationships, such as feeling responsible for their family and overall perceptions of connectedness with family members, allowed them to cope and promoted increases in positive psychological wellbeing. The men also coped with stressors by helping others in need, as well as promoting friendly personal engagements with others as a way for them to increase their wellbeing and overall sense of self-worth. Being respectful of others, especially their elders, and expressing that respect through lending a helping hand, were important values and behavioral acts for the men. Being selfless not only influenced their ability to cope with their daily lives, but their perceived benevolence aligned well with their religiosity, which also improved their psychological wellbeing and capacity for coping.

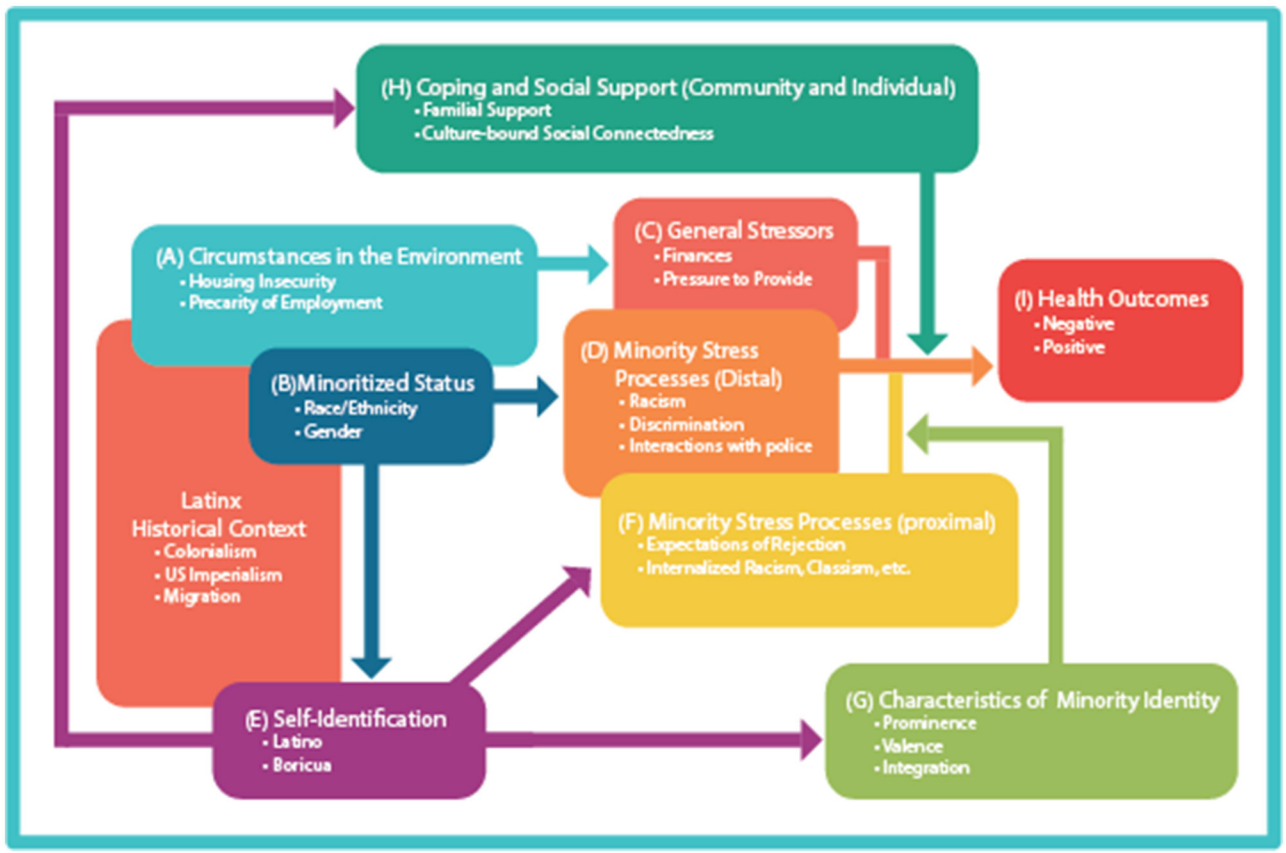

FIGURE 1 | Expanded minority stress model adapted for Latino men.

Participants also discussed how support within the community is a protective mechanism against daily life stressors, and subsequent negative psychological and societal outcomes. The men emphasized the importance of providing informational support to others by supplying information on resources and programs within the community that can supply fundamental support when needed. For example, the men promote programs like MOCHA in hopes that another person may benefit from obtaining the support and resources (i.e., employment, food, housing, and therapy) supplied by these community organizations.

Lending support was not only important to their sense of self at an individual level, but also important to their perception of community in general that was bound to their identities as Latinxs. The men spoke about the pride they felt toward their own culture and people, as well as pride in their collective ability to come together to provide support to others who may be in need. The men expressed the importance of providing aid to other Latinxs within their community to overcome the societal barriers they may encounter (i.e., language barriers, lack of transportation). Overall, the men agreed that providing support at individual and community levels, as well as their overall social connectedness through specific relationships, influenced positive coping behaviors in the face of stressors.

Expanding Minority Stress Models: Inclusion of Historical Contexts

Our findings highlight important deviations from the stress process considerations posited by the MSM. Particularly, interview-triggered discourse about stress, racism, and discrimination also elicited discussion about men's experiences with movement and migration, especially as it related to Puerto Rico's deleterious history of colonization, continued territorial possession of the island, the men's perception of their standing as second-class citizens in the U.S, and paternalism. As one participant put it: "We're the adoptive children of the United States." When asked to discuss the stressors that may be unique to Latino men living in the U.S., participants at times filtered and contextualized day-to-day stressors through an understanding of the U.S.-Puerto Rican political dynamics that have resulted in the diasporic and often substandard conditions of Puerto Ricans living on the mainland.

Several men highlighted the larger violence of colonization and economic impact of ongoing U.S. policies. One man considered racialization and violence in light of imperial subjugation: "So why are there White Mexicans? Why are there Brown Mexicans? Why is the Boricua Brown? Why are there Boricuas Latinos? Because of the violence." This violence he

refers to is the history of conquest by imperial powers—first from Spain, then the U.S. Another participant reflected on violent conquest as he spoke about his pride for Puerto Rican culture:

> But then there is a downfall to [Puerto Rican pride] also because [our history] doesn't make you feel proud. Because Christopher Columbus killed Puerto Ricans. He made slaves out of Puerto Ricans. He stole and raped Puerto Ricans. And they celebrate his birthday, they have statues of him. And he was a cold-blooded thief and a murderer.

This abhorrence of Columbus' legacy was echoed by another participant and linked to other Native plunder: "Do you know what the crazy part is? White people were not the first ones here, Native Americans were...Yeah, but they…They killed… They took America away from them."

Participants discussed different forms of impoverishment on the island that they saw as linked to continued economic pillage and possession of the island. One participant referenced the current debt crisis: "you know we owe like thirteen or fifteen trillion dollars to the United States from Puerto Rico." In the next sentence he remarked on the large number of Puerto Ricans who have migrated from the island to the mainland: "Why don't they just make it another state? Everybody is over here. Holyoke is Puerto Rico, Springfield is half Puerto Rico, and Westfield is half Puerto Rico." Another participant linked the crumbling infrastructure in Puerto Rico left by years of U.S. disinvestment in the post-industrial era to its now substandard medical system and consequent impact on health:

> Why do the Latino have a higher rate of chronic diseases? Let's say, more than the White men in the United States.... See, to me it has to do from where we came from, because we come from an island...The United States has better hospitals, better medicine.

Another participant further reflected on the U.S. acquisition of Puerto Rican resources while failing to invest in its people: "How are you going to come to my land to establish business, to steal from us...and you going to slap us in the face also?"

Along with historical legacy, participants punctuated their interviews with stories of often difficult and violent life experiences directly or indirectly linked to migration from the island to the mainland and movement within the U.S. The stories foretold how these experiences have shaped their current realities:

> I came from Puerto Rico when I was fourteen. To better my family. My father was never with us. I had to help my family when I was in Puerto Rico. I left school to help my family, I worked for them. Until I came here, then slowly I started sending for them one by one… I started working, I had my own apartment. I sent for my mom, my little brothers, the little ones that were left...thank God, until I brought them all. We started a new life out here…

Similar to the story above, another participant also moved to the mainland while young and took care of his family:

> I came here when I was 10 years old. To Brooklyn, a real bad place… Life for me…was a draw. Yeah because from where they took us, they took us to a jungle you know. Something horrific … We moved to Pennsylvania and the things that happened to my mother and the rebellion that I saw in the world. I was rebellious to the world, because of the things that happened to us, that happened to my mother.

One man spoke of the suffering he experienced here in the U.S.—although the "Island is bad," it is "a thousand times [better] there." He stressed—"You suffer. You suffer. You suffer here."

One repeated type of suffering centered on language acquisition and treatment as second-class citizens. One participant reflected: "A lot of the White people are racists. When they hear the accent, you notice it. The majority, the first thing they say is 'We are in America, not[exp] Puerto Rico." Another participant spoke of expectations on the mainland that exacerbate stress:

> The White man is from this country. Not us. We have to get accustomed to this country. We have to learn their language...and we have to learn their rules … And we were not born with those rules, we learn them here. It's harder. It's not your place. You can't do whatever you want like in your country. There are different rules, different norms, different politics. Everything is different.

Lastly, another participant's response exemplified how the men sensed their own second-class status on the mainland:

> It damages your mind… In the United States it is difficult to be Latino, because, because there's, there's… the matter of humiliation. But if we think about it, we are part of the United States. Because, right away as soon you are born, the first thing you get is your birth certificate. And it says American citizen. Even though you don't speak English.

DISCUSSION

The purpose of this work was to better understand the stressors faced by Puerto Rican men in the U.S. Northeast using a previously developed model used for minoritized populations. Our findings yielded expected parallels between our sample's stress processes and the pathways delineated by Meyer's MSM. Nevertheless, important deviations were present, particularly when considering movement and migration experiences and the historical context of U.S. colonialism.

Participating men referenced the complicated history of colonization by the U.S. in Puerto Rico as the genesis of collective misery for the Puerto Rican body politic. Our data indicates that these understandings were used by participants to contextualize their own current realities. This suggests that some participants use this legacy of colonialism and violence against Puerto Ricans—on the island and mainland—to make sense of their experience with everyday stressors, including those rooted in lived and vicarious prejudice, racism, discrimination, and marginalization. Importantly, the historical contexts played out in both stories of collective histories as Puerto Ricans, as well as in more individualized movement and migration stories. Importantly, participants were able to find parallels between their experiences and that of other colonized people

by linking personal to political storied similarities. All told, the stories highlighted participants' own indigenous theorization that health-detrimental conditions in the present are part and parcel of a colonially violent past. In its current configuration, when the MSM is applied to the stress experience of the Puerto Rican population, particularly that of stateside Puerto Rican men, it falls short in etching out the often-obscured historical trajectories of stress, i.e., the health consequences of the continued colonial territory of Puerto Rico by the U.S. and the historical and present-day causes and ensuing stresses of resulting mass movement and migration. The MSM can aid in *describing* the structures and conditions that lead to stress, yet what it does not do is elucidate a historical lens to further probe an underlying issue: Why are so many Puerto Ricans living in the U.S. Northeast in the first place? Furthermore, why do they continue to emigrate from the island, which for many, this exodus has contributed to adverse health outcomes? The answer lies in a history laden with violence—the plunder and expropriation of people from their land by larger political economic forces (Spain, then the U.S.) and continued neoliberal policies and ensuing economic stagnancy, as well as climate injustices, that ravage livelihood on the island.

Others have adopted an historical lens to explain population-based health disparities: stress levels and adverse health outcomes among Black Americans cannot be understood without considering the history of enslavement (Dozier and Munn, 2020) and the afterlife of slavery (Davis, 2019); epidemics of communicable and non-communicable disease in South Africa cannot be understood without the history of colonial subjugation and apartheid (Coovadia et al., 2009), just as the history of Māori Indigenous people must be linked to the colonial history of New Zealand (Reid et al., 2019); disproportionate rates of diabetes in Indigenous populations cannot be understood without their shared experiences of colonization and expropriation of land (Fortier, 2008; Voaklander et al., 2020) and the brutal history of residential schools (Howard, 2014); and increased risk of cardiometabolic disease amongst Indigenous populations can also not be explained without considering the historical trauma of subjugation (Lewis et al., 2021). An expanded MSM model for Puerto Rican men adds to this literature and provides a theoretical underpinning and best-fit framework upon which to further strengthen and codify future intervention that gives weight to highlighting history and how this impacts the present. Probing deeper not only helps our collective approach to understand stress processes in marginalized Latinx communities in general (many of whom migrate to the U.S. due to imperial forces) but can potentially strengthen multi-level intervention approaches and our continued questioning of the larger and persistent political economic forces that drive inequities in health outcomes.

As Meyer argues, it is vital to have multilevel interventions. While we continue to push for individual coping mechanisms to address stress (such as therapy, healthy eating, and exercise) and community-based interventions (such as more resources to strengthen disadvantaged neighborhoods, build infrastructure, create jobs and affordable housing), we must also include the culpability of continued austerity measures and the U.S. colonial hold on Puerto Rico. Activism and advocacy amongst and alongside Puerto Rican communities must challenge continued colonial oppression. The U.S. treatment of the island is a critical determinant of stress-filled living conditions for Puerto Ricans on the island, subsequent stress-induced movement and migration, and consequent poor health outcomes for Puerto Ricans on the mainland. The U.S. has a responsibility to the Puerto Rican people, and thus interventions must not stop at individual or community levels.

A recent article in *Pedagogy in Health Promotion* argues that public health degree programs do little to teach about the historical origins of health inequities (Fleming, 2020). Yet, the historical connections to present-day health inequities are crucial for understanding the root causes of suffering and therein informing multilevel interventions (Dozier and Munn, 2020; Fleming, 2020). An historical perspective is essential to illuminate that "present-day inequities in the United States were constructed over time" (Fleming, 2020, p. 254), thereby strengthening both the analysis and approach to addressing disparities. A historical lens helps to bolster a wider structural analysis to health disparities and takes the emphasis off of individual blame and choice (Fleming, 2020). Rather, we place the individual within the context of their immediate environment and larger historical and structural factors of a given society to better understand the intricate pathways leading to the biological embodiment of stress.

Fleming's assertion calls to mind the work of medical anthropologist and physician Paul Farmer, who is well-known for his decades-long dedication to addressing global health inequities and examining the impact of historical structural violence on the creation and reproduction of preventable suffering and disease (Farmer, 1999, 2005). Suffering, he writes, "is 'structured' by historically given (and often economically driven) processes and forces that conspire—whether through routine, ritual, or, as is more commonly the case, the hard surfaces of life—to constrain agency" (1999, p. 40). Here, Farmer writes about how one cannot understand (or find concrete solutions to) the AIDS epidemic in Haiti without understanding the long history of colonization and political violence that has ravaged the country. Individually embodied suffering (whether that is physical and/or psychological) must be continually linked to both historical legacies and the consequent structural edifices of society.

Strengths and Limitations

Historically speaking, Latino men are a difficult group to engage in health-related research (Rhodes et al., 2018; Valdez and Garcia, 2021). As a result, there is great strength stemming from the opportunity to engage Puerto Rican men in vulnerable and open dialogue about their lived experiences and the roots of their acute and chronic stressors. We believe that our approach to recruit and engage Latino men in community-based, non-clinical settings with a team of bilingual and bi-cultural peer mentors was key to our collective success. There is also a great deal of strength that stems from the rigor of our qualitative analysis and the findings they yield. Additionally, the insights shared by participants provide us with a paradigm shifting approach to examining stress processes in Latinx communities, which will be imperative to future intervention efforts with these populations.

Although the current study includes valuable insights of a seldom-engaged community to emphasize the importance of incorporating historical legacies within the MSM model, and thus, in future interventions to tackle health disparities, the study is not without its limitations. The work to expand the MSM to be responsive to the lived experiences of no/low-income Puerto Rican men was done prior to the emergence of COVID-19 and does not adequately account for the compounded effects of the pandemic on stressors and coping mechanisms. This is of particular importance, given that the Latino population in the U.S. has been disproportionately affected by the COVID-19 fallout (Shah et al., 2020; van Dorn et al., 2020). Another limitation, as with most qualitative inquiry, is the limited generalizability of our findings. The data collected in this study represent a limited geographical and cultural cross section of Latinx communities and, thus, cannot reflect the lived experiences of the vastly heterogeneous population of Latinxs living across the U.S. Nevertheless, as indicated in our data and supported by the literature, parallels in historical and current experiences with colonization and imperialism and resulting marginalization exist across Latinx communities, which warrants a closer confirmatory analysis. Future research should explore perceptions of the impact and influence of histories of subjugation and life trajectories of movement and migration on stress and health.

An additional consideration and potential limitation important to our understanding of the stress process lies at the intersection of historical context and the creation of Latinx manhood and masculinity. Research on the effects of self-conceptualizations and expressions of manhood and masculinity and its influence on stress continue to grow. Nevertheless, these notions were not explicitly present in the current data which warrant future inquiry that more precisely examines how a history of violent colonization, and the loss of power, agency, language, and culture also has an effect on the creation of masculinity which in turn has an effect on stress processing and coping.

CONCLUSION

Our work adds to the literature a confirmation of how stressors in one specific minoritized community map onto a previously developed heuristic framework and allow us to use this framework with more confidence. Nevertheless, our ability to further contextualize the lived experiences and stressors of Puerto Rican men in the U.S., and the historical circumstances that shape their current realities, as well as their shared understandings of these realities is important to consider as we work to expand the MSM to guide intervention development. An expanded framework allows us to take stock of the past to understand our present and better map a just future. This is best exemplified by the words of Melendez (2003), one of the founders of the New York chapter of the Young Lords, as articulated in his memoir:

> For all its influence on people's lives, history often seems more like a silent cloud than a guiding hand. No matter how subtle or silent, our history has a profound influence on our present and our future. If we search carefully enough, its path can be traced through the deeds and hopes of our ancestors to the very source and foundation of ourselves. You either claim your history or you lose authority over your future.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by University of Massachusetts Amherst Institutional Review Board. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

LV conceptualized the study and conducted all data collection. LV, AM, and MB analyzed and interpreted the data. LV and AM wrote the initial draft of the manuscript. AG provided supervision and review and editing to the manuscript. All authors had full access to all the data in the study, take responsibility for the integrity and accuracy of the data analysis, contributed to read, and approved the final version of the manuscript.

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Gender Self-Confidence as a Protective Factor for Suicide Risk: Analysis of the Sample of Lithuanian Men

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Background: Along with other suicide risk factors, masculinity has been analyzed as an important subject for suicidal behavior in men. This study examines masculinity as a gender self-confidence which is the intensity of an individual's belief that he meets his standards for masculinity. We use Hoffman and her colleague's concept, which provides two theoretical constructs as elements of gender self-confidence: gender self-definition and gender self-acceptance. Gender self-definition relates to how salient masculinity is in one's identity; gender self-acceptance relates to how positively one views his masculinity.

Methods: The quantitative research approach was applied in the study. The survey with a nonprobability quota sampling design was implemented to collect the data. The sample consisted of 562 Lithuanian men from various age groups and regions. The age of participants varied from 18 to 92 years ($M = 42.99$, $SD = 17.18$); 40.9% of men were from cities, 28.1% from towns, and 30.8% from rural locations. We used the Hoffman Gender Scale to measure gender self-definition and gender self-acceptance. Suicide risk was estimated with the Suicide Behavior Questionnaire—Revised. Patient Health Questionnaire-2 was used to measure depression symptoms as a controlled variable. Statistical analysis of regression and moderation was used to test the hypothesis.

Results: Higher gender self-definition and higher gender self-acceptance were associated with lower suicide risk. The moderation analysis showed that in men with relatively low gender self-definition, the effect of gender self-acceptance on suicidality was larger than in men with high or moderate gender self-definition.

Discussion: We conclude that a stronger gender self-confidence is an important protective factor in male suicide risk. Both, a smaller part of masculinity in one's identity and a negative view of one's masculinity have a cumulative effect on increased suicide risk. The findings have been discussed in accordance with the theories that explain suicidal behavior through the lenses of self-concept.

Keywords: suicide, men suicide, gender self-confidence, masculinity, suicide prevention

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INTRODUCTION

Masculinity is widely analyzed as a significant factor for men's mental health, including suicidal behavior (Liddon and Barry, 2021). Studies find that men are at a higher risk for suicidal behavior if they conform to masculinity norms of self-reliance (Coleman, 2015; Pirkis et al., 2017; Genuchi, 2019; King et al., 2020), restricted emotionality (Galligan et al., 2010), and violence (King et al., 2020). Some studies (Houle et al., 2008; Easton et al., 2013; O'Beaglaoich et al., 2020) examine masculinity norms as a general construct instead of specific dimensions or patterns; therefore, in those cases, it is difficult to understand what specific aspects of masculinity are linked to suicide behavior, given that not all masculinity norms are associated with mental health issues (Wong et al., 2017).

Qualitative studies on suicidology emphasize the importance of the theme of masculinity to suicidal behavior. A loss of economic control, gender role reversal, and fear of marital loss were found to be threats to masculinity that led to suicidal behavior in Ghana (Andoh-Arthur et al., 2018). The study in Bangladesh also highlighted masculinity-related themes (such as a failing provider, sexual impotency and infidelity, and masculine self-esteem and respect) to increase distress and induce suicidal behavior (Khan et al., 2020). A Norwegian study of young male suicide cases identified the characteristics of a suicide process that represents compensatory masculinity: men were intensively pretending that there was no trouble (because weakness was never allowed) and then in a short time they died by suicide leaving a note that he does not blame anyone but himself (presentation of self as heroic) (Rasmussen et al., 2018). Studies in Ireland (Cleary, 2012) and Northern Ireland (Jordan et al., 2012) indicate that some men may suppress and conceal emotional pain due to their beliefs about masculinity. Research conducted in various countries shows some universality in the association between masculinity and suicidal behavior.

Some studies indicate positive aspects of masculinity in suicidal behavior. According to the research carried out in Canada, depressed men felt that the masculine role of a family protector mitigated suicide risk and encouraged them to seek help (Oliffe et al., 2012). A study conducted in Sweden showed that men with masculine interests (leisure interests and occupational preferences) were less likely to die by suicide (Månsdotter et al., 2009). Masculinity norm of striving for success, power, and competition was found to be a protective factor for suicidality in an adolescent sample (Galligan et al., 2010). Higher scores of masculine traits were associated with a lower possibility of suicidal thoughts, but only in older adults (Hunt et al., 2006). However, in the same study, older adults with more traditional attitudes toward gender roles were at higher suicide risk. Therefore, some dimensions or patterns of masculinity might be a risk factor for suicide, while others appear to be a protective factor.

Liddon and Barry (2021) argue that in many studies about masculinity, scientists use "a deficit approach" which views masculinity as a source of mental health issues. For example, the Gender Role Strain paradigm, which was called "a standard model" in the field of masculinity studies (Pleck, 2017), explains that masculinity ideology leads men to persist in dysfunctional behaviors and also directly creates trauma in their socialization (Pleck, 1995). However, being a man is not only being masculine, it is also a part of identity, which is why one-sided or excessively negative views of masculinity might misrepresent the whole picture. Also, questionnaires that evaluate masculinity norms are usually based on socially constructed images of masculinity and represent stereotypical traits or behaviors instead of subjective personal meanings about his masculinity (Hoffman et al., 2000).

This study deals with masculinity in accordance with a concept of *gender self-confidence,* introduced by Hoffman and her colleagues (2000), which is defined as "the intensity of an individual's belief that he meets his standards for masculinity (maleness)" (p. 481). According to the model of Hoffman et al. (2000), gender self-confidence consists of two factors: *gender self-definition* and *gender self-acceptance*. *Gender self-definition* refers to "how strong a component of one's identity one considers one's femininity or masculinity to be" (p. 494). Men with a very strong gender self-definition attribute much importance to their maleness (Hoffman, 2006) and masculinity is a strong component of their identity (Hoffman et al., 2005). *Gender self-acceptance* refers to "how comfortable an individual is as member of his or her gender" (Hoffman et al., 2000, p. 495). Men with strong gender self-acceptance can be more relaxed about themselves, accept, value, and respect themselves in terms of their maleness (Hoffman et al., 2000; Hoffman, 2006).

Gender self-confidence is encompassed by broader constructs of *gender identity* and *gender self-concept*, as Hoffman (2006) explains: "gender self-confidence was grounded in an individual's *gender identity*, defined as security about one's own femaleness or maleness" (p. 188, italics original) and "an individual's *gender identity* was, in turn, encompassed by an individual's *gender self-concept*, which I defined as the broad perception of self as a man or a woman" (p. 188, italics original). In the analysis of gender self-confidence, we also grasp gender identity and gender self-concept, which previously have not been studied from the perspective of men's suicide.

The purpose of this research is to analyze the relationship between gender self-definition, gender self-acceptance, and suicidality. Studies indicate that gender self-acceptance, but not gender self-definition, is related to higher subjective well-being (Hoffman, 2006); therefore, we hypothesize that gender self-acceptance is a protective factor for suicide risk, but gender self-definition does not affect suicidality. The question is if masculinity covers a greater part of a man's identity, does it make gender self-acceptance a more important factor for suicide risk? The analysis of this research will evaluate whether gender self-acceptance and suicidality interrelate differently depending on different levels of gender self-definition. Accordingly, the second hypothesis of the study states that in men with lower gender self-definition, gender self-acceptance has a weaker effect on suicidality than in men with stronger gender self-definition. Depression symptoms were included as a controlled variable, given their well-known associations with suicidality (Ribeiro et al., 2018).

TABLE 1 | Sociodemographic characteristics of the sample.

	n	%
Age		
18–29	157	27.9
30–39	107	19.0
40–49	84	14.9
50–59	97	17.3
60–69	70	12.5
70+	43	7.7
Place of residence		
City	230	40.9
Town	158	28.1
Rural location	173	30.8
Marital status		
Married	303	53.9
Divorced	209	37.2
Never married	36	6.4
Widower	14	2.5
Employment		
Employed	419	74.6
Unemployed	41	7.3
Student	41	7.3
Retired	59	10.5

Missing values for age = 4; place of residence = 1; employment status = 2.

TABLE 2 | Means, standard deviations of the variables and correlation coefficients.

Variable	*M*	*SD*	1.	2.	3.	4.
1. SBQ-R	5.47	2.95	–			
2. GSD	3.59	1.32	−0.295**	–		
3. GSA	4.56	1.03	−0.330**	0.575**	–	
4. PHQ-2	1.58	1.62	0.492**	−0.299**	−0.389**	–
5. Age	42.99	17.18	−0.310**	0.329**	0.089*	−0.316**

TABLE 3 | Hierarchical regression analysis with SBQ-R as dependent variable.

Variables	*B*	*Beta*	*t*	*p*	*CI*
Step 1					
GSD	−0.347	−0.155	−3.135	0.002	[−0.565; −0.130]
GSA	−0.689	−0.240	−4.857	<0.001	[−0.968; −0.410]
Step 2					
GSD	−0.105	−0.047	−0.990	0.323	[−0.313; 0.103]
GSA	−0.418	−0.146	−3.069	0.002	[−0.686; −0.150]
Age	−0.028	−0.164	−4.027	<0.001	[−0.042; −0.014]
PHQ-2	0.670	0.369	8.889	<0.001	[0.522; 0.819]
Step 3					
GSD	−1.284	−0.574	−3.067	0.002	[−2.106; −0.461]
GSA	−1.110	−0.387	−4.057	<0.001	[−1.647; −0.572]
Age	−0.029	−0.166	−4.107	<0.001	[−0.042; −0.015]
PHQ-2	0.661	0.354	8.812	<0.001	[0.513; 0.808]
GSD*GSA	0.237	0.700	2.910	0.004	[0.077; 0.398]

Step 1: *Adj.* $R^2 = 0.121$, $F_{(533)} = 37.901$, $p < 0.001$. ***Step 2:*** *Adj.* $R^2 = 0.288$, $F_{(531)} = 55.190$, $p = 0.000$, *F change* $p < 0.001$. ***Step 3****: Adj.* $R^2 = 0.298$, $F_{(530)} = 46.466$, $p < 0.001$, *F change* $p = 0.004$.

MATERIALS AND METHODS

Participants

A non-probability quota sampling method was used to ensure that people from different places of residence and age groups would be involved in the sample. Quota sampling improves the research participants' diversity because some characteristics of the target population are acknowledged (Neuman, 2007). We identified relevant quotas (male/female; residents from cities/rural locations; age groups from 18 years and further every 10 years) and set the required respondents from each quota. The number was based on the proportions of different groups in the population of Lithuania according to the data from the Lithuanian Department of Statistics. We ended the data collection when each quota was accomplished. However, some of the groups appeared to be larger in the final sample, because younger men and city/town residents were more active in filling out the online questionnaire.

A total of 1293 women and 562 men participated in the survey, but the subsample of men was chosen for this study. Therefore, the final sample consisted of 562 Lithuanian men from various cities, towns, and rural locations in the country. The average age of the sample was 42.99 ($SD = 17.18$), varying from 18 to 92 years. **Table 1** shows the sociodemographic characteristics of the sample in greater detail. The quota sampling assured the variation in place of residence and age; however, as shown in **Table 1**, the sample is heterogeneous in marital status and state of employment too.

Measures

The Hoffman gender scale (HGS); (Hoffman et al., 2000) consists of two subscales that represent two theoretical constructs: gender self-definition (GSD) and gender self-acceptance (GSA). Each subscale consists of seven items and a 6-point scale from strongly disagree (1 point) to strongly agree (6 points). A separate mean score for each of the two subscales is calculated for the final score. Subscale mean scores can range from 1 to 6, with higher scores reflecting stronger levels of the construct. An example for GSD: "I define myself largely in terms of my masculinity," and for GSA: "My sense of myself as a male is positive." HGS was translated to the Lithuanian language with permission from the authors, back translation procedures, and a pilot study was conducted before the research.

The HGS was not validated in Lithuanian population before, but the scale was chosen for its theoretical background, which fits the purposes of the study. Given that Lithuanian scale has not been used previously, the psychometric properties of HGS were evaluated via factor analysis. The confirmatory factor analysis (CFA) indicated a poor fit of the original model: TLI = 0.876, CFI = 0.897, RMSEA = 0.117, $X^2(76) = 635.407$, $p = 0.000$. Standardized regression weights varied from 0.576 to 0.846 and R^2 varied from 0.331 to 0.716. The exploratory factor analysis showed a good fit of the original model (KMO = 0.934,

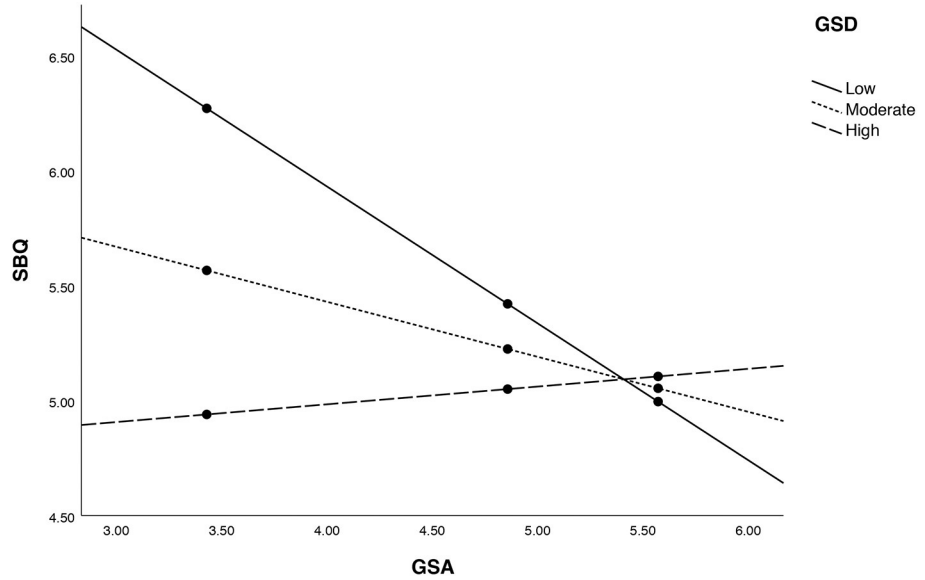

FIGURE 1 | The visual representation of moderation effect.

BTS $X^2(91) = 5448.954$, $p < 0.001$, eigenvalues 7.49 and 1.92, explaining 67.18% of the variance), but item 4 showed low factor loadings for both factors: 0.484 and 0.441. Item 4 was removed from the scale, which resulted in acceptable parameters in CFA: TLI = 0.934, CFI = 0.948, RMSEA = 0.090, $X^2(61) = 326.286$, $p < 0.001$. Standardized regression weights varied from 0.657 to 0.861 and R^2 varied from 0.431 to 0.741. Internal consistency of the subscales: gender self-definition *alpha* = 0.911; gender self-acceptance *alpha* = 0.922.

Suicide Behavior Questionnaire—Revised (SBQ-R) (Osman et al., 2001) was used to assess the overall suicidality. SBQ-R consists of four items that assess the life-long history of ideation and attempts, frequency of suicidal ideation, threats of suicide, and the likelihood of suicide completion. The total score on the measure ranges from 3 to 18, with higher scores reflecting a greater risk for suicidal behaviors. The instrument was translated to the Lithuanian language with a back-translation procedure and a pilot study before the current research.

SBQ-R is not validated in the Lithuanian population, but it was chosen for its high psychometric properties in other studies (Chodkiewicz and Gruszczyńska, 2020), given that no other validated Lithuanian scale that evaluates overall suicidality exists. This study suggests that SBQ-R is suitable for Lithuanians, because CFA with one factor indicated a good model fit: TLI = 0.948, CFI = 0.990, RMSEA = 0.080, $X^2(2) = 9.180$, $p = 0.010$. The R^2 values varied from 0.286 to 0.653 and standardized regression weights varied from 0.535 to 0.808. The internal consistency of SBQ-R was good (*alpha* = 0.782).

Patient Health Questionnaire-2 (PHQ-2); (Kroenke et al., 2003). PHQ-2 consists of two first items from PHQ-9 and it inquires to estimate anhedonia and depressed mood in the last 2 weeks by choosing one of the categories: not at all (0 point), several days (1 point), more than half the days (2 points), and every day or nearly every day (3 points). PHQ-2 shows a good construct and criterion validity for depression screening (Kroenke et al., 2003) and has a very high correlation with the full PHQ-9 version (Dadfar and Lester, 2017). The scores of both items were summed, and they ranged from 0 to 6 points. The Lithuanian version of PHQ-2 is provided by the Multicultural Mental Health Resource Centre.

PHQ-2 is not validated in the Lithuanian population; however, PHQ is widely used and shows good psychometric characteristics in other Lithuanian studies (Kazlauskas et al., 2022). In this study, the factor analysis of PHQ-2 also indicates the appropriateness of the scale. The exploratory factor analysis showed that two items could be considered as one factor in the model (KMO = 0.500, BTS $X^2(1) = 379.229$, $p < 0.001$) with eigenvalue 1.702, explaining 85.10% of the variance, and factor loadings 0.923 and 0.923. The internal consistency of PHQ-2 was good (*alpha* = 0.825). The psychometric characteristics of PHQ-2 were very similar to those in other studies (Dadfar and Lester, 2017).

Demographic characteristics, including the state of employment, marital status, place of residence, age, and so on, were collected.

Procedure

Data were collected via a survey, conducted both online and in paper-and-pencil format; 490 (87.19%) men filled the online questionnaire and 72 (12.81%) men filled the printed questionnaire. Data collection was done between 17 June 2020 and 12 April 2021.

The invitation to participate in the online survey was distributed via social media, emails to public libraries, culture centers and elderships in municipalities, various associations, educational institutions, and some corporations that are situated in the regions. Overall, 102 emails were sent to different

addresses. Research participants who filled out the printed questionnaire were recruited face-to-face in some of these institutions. Interviewers contacted the head office of the institution by phone in advance and arranged the appropriate time to come and invite people to participate in the study. Three institutions were contacted this way: the public library, the culture center, and the corporation.

After filling out the online questionnaire, information about possible institutions for emotional support (helplines) and professional psychological help (crisis centers, primary care for mental health) was provided. In addition, along with this information, the encouragement to seek help if needed was presented. The same information was provided on the last page of the printed questionnaire, which could be detached and given to the participant. No personal information was inquired about in the questionnaire and confidentiality was ensured. All filled questionnaires were delivered to the office of the Centre for Suicidology, where interviewers entered the data into the digital database.

Statistical Analysis

During the initial analysis, the relations among variables were estimated by the Pearson correlation coefficient. The magnitude of correlations was evaluated using Cohen's (1988) terms, where $r = 0.10$, $r = 0.30$, and $r = 0.50$ are considered small, medium, and large in magnitude. The hierarchical regression analysis was conducted to test the first hypothesis. The regression analysis evaluates a prognostic effect of the independent variables on a dependent variable, which indicates whether GSD and GSA (independent variables) are protective factors for the SBQ-R (independent variable). Regression analysis also estimates the effect of the interaction between GSD and GSA on SBQ-R, which represents a moderating effect.

Further, the moderation analysis was conducted in more detail and visualized with Hayes's (2022) PROCESS 3.5.3v macro, which is a modification to SPSS that computes regression analysis for various combinations of mediators, moderators, and covariates. In this study, we applied the moderation model, in which the moderator variable influences the magnitude of the causal effect of an independent variable on a dependent variable (Hayes, 2022). Specifically, we tested the second hypothesis of this study by evaluating whether GSD (moderator) influences the magnitude of the causal effect of GSA (independent variable) on SBQ-R (dependent variable). Both the regression and moderation analyses included PHQ-2 and age as controlled variables because of their strong association with suicidality and thus possible role as confounding variables. The confounding variable threats the validity of the analysis, which estimates the relationship between variables, and thus in moderation analysis, the potential confounding variables are held constant (Hayes, 2022).

No deviations from normality in terms of variable skewness and kurtosis were observed, apart from the suicidality variables. The data on SBQ-R were slightly skewed (1.65) and the kurtosis was slightly higher (2.8) than would be expected in a normally distributed measure. However, given that this measure of suicidality was used in a general population sample, some deviation from the normal distribution could be expected; therefore, because the deviation was small while the sample size is large, no impact on the accuracy of statistical test was expected (Field, 2018) and no transformation was used.

TABLE 4 | Conditional effects of GSA on SBQ-R among those with relatively low (2.1667), moderate (3.6667), and high (5.0000) GSD.

	Effect	*se*	*t*	*p*	*CI*
Low GSD	−0.5953	0.1484	−4.0129	0.0001	[−0.8868; −0.3039]
Moderate GSD	−0.2393	0.1486	−1.6107	0.1078	[−0.5311; 0.0525]
High GSD	0.0772	0.2174	0.3551	0.7227	[−0.3499; 0.5043]

RESULTS

The results of SBQ-R indicated that 190 (33.8%) research participants had no suicide risk; their score SBQ-R was 3, which is the lowest possible score on the scale. In total, 369 (65.7 %) research participants indicated at least some suicidality ranging from 4 to 18 points of SBQ-R. Descriptive statistics and correlation analysis are presented in **Table 2**.

SBQ-R correlated significantly with all other variables. Higher scores of SBQ-R were associated with greater PHQ-2 and the correlation was strong [$r_{(558)} = 0.492$, $p < 0.001$]. SBQ-R had a negative association of medium magnitude with both GSD [$r_{(549)} = -0.295$, $p < 0.001$] and GSA [$r_{(545)} = -0.330$, $p < 0.001$]. Age had a significant medium correlation with SBQ-R, which indicated that younger men had higher scores of SBQ-R than older men [$r_{(555)} = -0.310$, $p < 0.001$]. A younger age is also associated with higher PHQ-2 [$r_{(557)} = -0.316$, $p < 0.001$] and lower GSD [$r_{(548)} = 0.329$, $p < 0.001$]. Age had no significant association with GSA, because the coefficient did not reach a significant level [$r_{(544)} = 0.089$, $p = 0.039$].

The hierarchical regression analysis was conducted for SBQ-R as a dependent variable (**Table 3**). The analysis showed that GSD and GSA were significant predictors in the Step 1 model (*Adj.* $R^2 = 0.121$, $F_{(533)} = 37.901$, $p < 0.001$), but those two variables accounted for only 12% of the overall suicide risk. In Step 2, age and PHQ-2 were added to the model as controlled variables which improved the model significantly (*Adj.* $R^2 = 0.288$, $F_{(531)} = 55.190$, $p < 0.001$, *F* change $p < 0.001$), accounting for 29% of the overall suicide risk and removed the significant prognostic effect of GSD ($p = 0.323$). In Step 3, the interaction between GSD and GSA was added for a moderation analysis and showed a significant prognostic effect for SBQ-R ($p = 0.004$), which indicated the possibility that the interaction between GSA and SBQ-R depended on GSD. A further analysis was conducted with PROCESS macro for SPSS (Hayes, 2022) for specifying the moderating effect of GSD with age and PHQ-2 as covariates in the model.

First of all, the moderation analysis with PROCESS confirmed the interaction effect ($p = 0.0038$). The visualization of the moderation effect is presented in **Figure 1** and the indices of conditional effects are presented in **Table 4**.

In men with a relatively high or moderate GSD, the effect of GSA on SBQ-R was not significant ($p = 0.1078$ and 0.7227), but

in men with a relatively low GSD, the effect of GSA on SBQ-R was larger and significant ($p = 0.0001$). It means that GSD has a moderating effect on the association between GSA and SBQ-R in a way that a lower GSD indicates a stronger association.

DISCUSSION

The findings suggest that masculinity as gender self-confidence has a link to suicidal behavior. In this study, gender self-definition and gender self-acceptance were analyzed as components of gender self-confidence which is encompassed by gender identity and gender self-concept. We hypothesized that gender self-acceptance is a protective factor for suicide risk, while gender self-definition has no effect on suicidality, but findings only partly supported this assumption. Both gender self-definition and gender self-acceptance were found to be protective factors for suicide risk. A greater part of masculinity in a man's identity (gender self-definition), as well as a stronger comfortability with his own masculinity (gender self-acceptance), are linked to lower suicide risk.

Although the controlled variables removed the significance of gender self-definition, further analysis showed the moderating role of this variable, which represents our second hypothesis. We hypothesized that in men with lower gender self-definition, gender self-acceptance has a weaker effect on suicidality than in men with stronger gender self-definition. But findings showed the opposite trend: in men who consider masculinity as a large part of their identity, the comfortability with their masculinity as it is has a much weaker link or no link to suicide risk. However, in men whose masculinity comprises a small part of their identity, negative attitudes toward their masculinity have a strong link to suicide risk. It means that gender self-definition or identity with salient masculinity is a resource that may give resilience in some circumstances.

If masculinity does not play a big role in a man's identity, it does not mean that masculinity is eliminated and a man's opinion about his masculinity and how he feels about it has no importance. On the contrary, a smaller part of masculinity in one's identity and a negative view of one's masculinity have a cumulative effect on the increased suicide risk. The results coincide with Hoffman et al.'s (2000) theoretical explanation that there might be different combinations of levels of gender self-definition and gender self-acceptance, and these combinations might be under consideration in the analysis of gender identity.

We may link the findings to some existing theories of suicidal behavior which explain it through the lenses of self-concept, as we also analyze masculinity as a part of gender self-concept. Baumeister's (1990) escape theory treats suicide as an escape from self, which is seen as "inadequate, incompetent, unattractive, or guilty" (p. 91) due to high personal standards or circumstances that are below personal standards. Our finding that low gender self-acceptance is associated with a higher suicide risk means that if a man has very high standards for being masculine and it is extremely difficult to fulfill these standards or certain circumstances imply that he is not masculine enough in his personal view, and he might feel that suicide is a possible escape from the negative impact and problems implying that his masculinity is inadequate, incompetent, and unattractive. His awareness of his masculinity as a part of gender self-concept is unbearable and thus he seeks a way to escape it (Baumeister, 1990).

In Chandler's theory of personal continuity (Chandler, 1994; Chandler et al., 2003), suicide is explained as a result of disturbed self-continuity. During their developmental path, individuals use different strategies to maintain self-continuity which is the ability to see the sameness of one's identity through time. In the presence of life changes or during the move from one developmental stage to another, some strategies may become ineffective leading to the disturbance of self-continuity and the individuals' unconnectedness to his/her future. If some stressful life situations happen at the same time, individuals become vulnerable to suicide, because commitment to one's well-being in the future is lost and suicide is seen as a possibility (Chandler et al., 2003). We may assume that stronger self-definition might be a strategy to maintain self-continuity. Chandler et al. (2003) state that "if nothing about us remained the same to ensure our reliable re-identification—then life we ordinarily understand it would simply have no followable meaning" (p. 6). Being a man is a thing that will never change despite the continuously changing life circumstances, stress levels, or developmental challenges. This continuity, integrity, and robustness of gender identity give strength and even weakens the effect of negative attitudes toward man's masculinity. Probably, a stronger gender identity reinforces the motivation to find coping strategies in the presence of life adversities, even though they challenge masculinity.

Although some aspects of masculinity increase suicide risk (Houle et al., 2008; Galligan et al., 2010; Easton et al., 2013; Coleman, 2015; Pirkis et al., 2017; Genuchi, 2019; King et al., 2020; O'Beaglaoich et al., 2020) and male suicide prevention or therapeutic strategies targeted at these aspects are important, however, it is worth mentioning that another important factor for men is sustainability and support for gender self-definition, that is to say, masculinity in one's identity. Therefore, the task is not only to soften self-reliance (Pirkis et al., 2017) or restricted emotionality (Galligan et al., 2010) in men, but at the same time to acknowledge the need for masculine identity. This notion concurs with some critiques of public health campaigns for their irrelevance to men's needs and specific contexts (Chandler, 2021).

However, studies also indicate that challenging narrow beliefs about "real man" (Jordan et al., 2012) or promoting healthier masculinity (Trail et al., 2021) is a relevant direction for male suicide prevention. Finding a way to increase confidence and satisfaction with one's masculinity could reduce suicide risk. Also, a sense of belonging and strong social connections in the community (Trail et al., 2021) or support groups for men (Gosling et al., 2021) were found to be important factors for men's mental health, which may suggest that specific organizations, activities, or other informal groups for men might strengthen masculinity as a part of identity and thus improve the resilience in the face of life challenges.

Some limitations of the study might be noted. First, different findings may be found in countries of different cultural environments. Second, a current sample is very heterogeneous in

age, place of residence, marital status, and state of employment, but we may presume that different results could be found in separate groups of men, for example, in the diverse socioeconomic status, education level, occupation field, and others. Moreover, the population sample in this study is not representative, therefore the generalizations should be made cautiously.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article, further inquiries can be directed to the corresponding author/s.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Ethics Committee for Psychological Research at Vilnius University (REF number 47, 2020-06-15). The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

DGr, PS, SD, JR, and DGa contributed to the design and implementation of the research. DGr performed the calculations and wrote the manuscript with input from all authors. DGa is the director of the project. All authors revised and approved the submitted version.

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Exploring Teacher and Parent Perspectives on School-Based Masculinities in Relation to Mental Health Promotion

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The capacity for boys' and young men's mental health promotion to act *via* shifting masculine norms that are linked to poor mental health outcomes, highlights the need to improve the extent to which school-based programs can promote mental health through leveraging more positive embodiments of masculinity. To-date, the perspectives of parents and teachers on such processes are understudied. This qualitative study presents teacher and parent views regarding adolescent masculinities and avenues for school-based developmental programming for boys and young men. In this study, 16 individual qualitative interviews were undertaken with 10 parents (six females, four males), and six teachers (three females, three males), recruited from an independent all-boys' grammar school in Melbourne, Australia. Thematic analysis of parents' and teachers' perspectives indicated their perception of the role of context-dependent "public" and "private" masculinities, the influence of Australian masculinity norms, and the role of private boys' school cultures in the development of adolescent masculinities. Additionally, strategies for development encompassed participants' appetite for boys' exposure to positive role models, in addition to consistent and relevant developmental programming to support positive masculinity development. Findings have implications for efforts to support prosocial masculine identity development *via* school-based initiatives, as an avenue to promoting mental health of boys and young men.

Keywords: masculinity, adolescent, mental health, intervention, school

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INTRODUCTION

Suicide rates among boys and young men are approximately triple those observed in young women (World Health Organisation, 2014). Australian data indicate age-specific suicide rates (per 100,000 population) among 15–19-year-olds to be 16.9 for young men and 6.1 for young women; and among 20–24-year-olds, 24.9 for young men and 7.3 for young women (Australian Bureau of Statistics, 2020). This cements the need to explore the varied influences on the proliferation

of suicidality in boys and young men. A wealth of research has connected behavioral norms grounded in so-termed "traditional masculinity" with low rates of help-seeking for emotional problems in boys and young men compared to girls and young women (Slade et al., 2009), alongside evidence associating adherence to masculine codes of self-reliance with risk of suicidal thinking (King et al., 2020). Importantly, boys' and young men's perception that they are *expected* to behave in traditionally masculine ways (i.e., avoiding help-seeking in favor of self-reliance) by the people around them can be a driving force in sustaining these norms (Irvine et al., 2018). As such, further research is needed to uncover the social processes and contexts that continue to underpin boys' and young men's perceptions of the expectation to behave in accordance with traditional masculinity. Findings in this domain will help to refine school-based mental health promotion programs that aim to norm healthy prosocial embodiments of masculinity as a conduit to promoting boys' and young men's mental health.

Adolescent Masculinities

Social constructionist perspectives suggest that masculinities (i.e., the various ways of being and expressing one's gender as a boy or man) are learnt behaviors, attitudes and norms that define what it is to "be a man" (Connell, 1995). These meanings vary across cultures and contexts, and in-turn influence mental health outcomes in myriad ways (Robertson, 2007; Gough, 2018). In this sense, masculinity is not a homogenous concept, but rather, as proposed by Connell and Messerschmidt (2005), masculinities exist in multiple forms explicating the diversity of gendered expressions between and within cultures, time and individuals. Membership of varying hierarchical social categories also intersects with the embodiment of masculinities, such that, for example, variation across class, race, and sexualities (i.e., identification as heterosexual or a sexual minority such as gay or bisexual) will influence practices and performative behaviors in the enactment of masculinities, and in turn, mental health (Griffith, 2012).

There is long-standing recognition that rigid conformity to masculine norms can contribute to psychosocial and health-related problems among boys and young men (Wong et al., 2017; Rice et al., 2018). Abundant literature has linked rigid adherence to "traditional" masculine norms (e.g., stoicism, toughness, emotion suppression, and power over women) to a range of negative outcomes, including aggression, violence, substance misuse, reduced wellbeing, low help-seeking, and school disengagement (Young et al., 2002; Levant et al., 2009; Ueno and McWilliams, 2010; Wong et al., 2017; Ravn, 2018). Moreover, research has highlighted associations between conformity to norms of violence and self-reliance with risk of suicidal thinking in boys and young men (King et al., 2020). Boys who experience greater pressure to enact their masculine gender role are also more likely to experience depression, and in turn, increasingly likely to report suicide ideation (O'Beaglaoich et al., 2020).

During adolescence, boys and young men may experience heightened pressure to display or embody masculine ideals perceived as socially condoned in order to mark their difference from the embodiment of femininities (Connell, 1995). Put another way, boys and young men are often socialized to defend or contest perceived or actual judgment of their behaviors and identity aligning with feminine norms by proving their alignments to traditional masculinity (Vandello and Bosson, 2013). The foundation of masculinity is thought to be the rejection of that which is not masculine; the divergence of oneself from femininities or subordinate masculine identities (e.g., sexual minority men; Connell, 1995). This thinking has culminated in emerging understandings of the extent to which a certain archetype of masculinity can be policed for boys, such that they can suffer a sense of reduced social standing if they are perceived to violate the "norm" when it comes to enacting one's masculinity (Reigeluth and Addis, 2021). In the context of suicidality, the construction of help-seeking and relying on others as indicative of weakness or femininity in boys and young men is thought to, at least in part, precipitate reduced propensity to disclose distress in order to uphold an image of masculine self-reliance (Möller-Leimkühler, 2002; Seidler et al., 2016). While some studies indicate that adherence to masculinity norms may peak during adolescence around ages 15–18 (Rice et al., 2011; Herreen et al., 2021), researchers have also noted increasing flexibility in the enactment of masculinity norms by younger generations of boys and young men (Anderson and McCormack, 2018). Contemporary male youth in the global north are commonly thought to be engaging in a process of identity formation which requires a complex negotiation of modern-day expectations (e.g., engagement with feminism; help-seeking for emotional problems) against the backdrop of traditional masculinity expectations (e.g., power over women; emotional restriction and rigid self-reliance; Elliott, 2019). Crucially, therefore, understanding the contextual influences on this process of masculine identity expression enables a critique of the ways in which this traditional archetype of masculinity continues to influence the mental health of boys and young men.

School-Based Masculinity Development

One setting identified as critical to this process of masculine identity construction is the secondary school environment. Schools are key sites for the production and negotiation of male-coded behaviors, where certain features (e.g., the separation of male and female students in single sex schools) can influence enactments of masculinity (Martino and Meyenn, 2001). Students navigate a variety of formal structures (e.g., curriculum, policy) and informal structures (e.g., relationships with students, teachers) through which behavioral norms are regulated and enforced (Swain, 2006). Influences on adolescent masculinity development can permeate various interdependent settings, with secondary school as the epicenter. For instance, behavioral norms and expectations set in the home through parental modeling (and indeed those set in the home of one's peers) may permeate the school; and *vice versa*, where teachers can also model masculinities (Hickey and Mooney, 2018). Equally, parenting efforts to shape prosocial masculinities can be thwarted within the school environment, where peer-driven policing of adherence to traditional masculinities is strongest (Reigeluth and Addis, 2016). Parents, teachers and

boys' and young men's peers are therefore all active agents in the development of boys' gender concepts and understanding of their own masculinities (Connell, 1996; Odenweller et al., 2013; Bishop, 2017). Given this, understanding the perspectives of all parties is vital to appraising how masculinity is learnt, performed, enacted, and reinforced by boys and those around them in school settings (Weaver-Hightower, 2003; Hickey and Mooney, 2018). A large body of research has explored boys' and young men's experiences of the "policing" of adherence to traditional masculine norms in the school context (Reigeluth and Addis, 2016) where embodiment of "masculine" attributes is deemed a social "must" (MacLean et al., 2010). Yet to complement this literature, further research aiming to canvass the perspectives of parents and teachers on adolescent masculine identity development, and how these parties can best support gains made *via* school-based mental health promotion interventions, is warranted. Moreover, single-sex schools simultaneously occupy a position wherein traditional masculine norms can be both challenged and inadvertently reinforced; equity-driven, staff-, and student-led initiatives to encourage a wider school climate grounded in positive, prosocial masculinities could be a key agent of change here (Hickey and Mooney, 2018).

Building on a long-standing call for psychoeducational programs for boys and young men that aim to target restrictive masculine socialization (O'Neil and Luján, 2009), interventional research is beginning to capitalize on the school environment as a prime avenue for programs intended to shift the pervasiveness of traditional masculinity norms for boys and young men. One example in Australia is the Silence is Deadly program, recently evaluated by Calear et al. (2021). Delivered to boys and young men in Australian secondary schools, the program aims to provide psychoeducation regarding men's mental health, suicide and help-seeking, while communicating explicitly the role that adherence to traditional masculinity norms such as self-reliance and emotional restrictiveness can play in shaping negative attitudes toward help-seeking (Calear et al., 2017). Whilst positive effects of the program on help-seeking intentions were observed (Calear et al., 2021), there is scope to improve the extent to which such programs can achieve the complicated goal of shifting identification with masculinity norms. Researchers, boys and young men alike have long called for the need for positive, strength-based programming that does not simply tell boys and young men what not to be, but rather achieves this end indirectly *via* encouragement of a new, positive and prosocial archetype of masculinity that, for example, embraces enlisting professional help as indicative of psychological strength (Kiselica et al., 2016; Wilson et al., 2021a). Given shifting identification with masculinity norms is a long-term process involving multiple agents of influence across the school context (i.e., peers, parents, and teachers; Martino and Meyenn, 2001; Marmion and Lundberg-Love, 2004; Martino, 2008) further research is needed to explore the level of understanding of parents and teachers in school-based masculinity development. This will help to inform efforts to subsequently involve parents and teachers in mental health promotion interventions that are grounded in promoting healthy embodiments of masculinity.

The Present Study

While researchers have commonly discussed male students influencing role norm adherence of their peers in a student body (Reigeluth and Addis, 2016; Rogers et al., 2021), the instrumental roles of teachers and parents in male students' masculine identity development are under-researched. Foundational research has noted the influence of teachers on masculinity development among male students, particularly in the context of physical education where it has been suggested that male teachers in particular reproduce the norms characteristic of traditional masculinity, given its association with sporting prowess (Jackson, 2010; White and Hobson, 2017). Findings regarding the respective roles of parents and teachers in school-based masculine socialization will be readily translatable to school-based health promotion interventions designed to encourage positive masculinity (i.e., developmental progress toward the embodiment of human strengths by males; Wilson et al., 2021a) as a means to benefit mental health. Finally, regarding a worthy context to investigate parent and teacher perspectives on school-based masculinity development, private all-boys schools have been long discussed in the literature as presenting a unique context for the competitive enactment of hyper-masculinity among boys and young men (Hickey, 2010); yet the perspectives of the parents' and teachers connected to these schools remain under-researched to date.

As such, the aim of the current study was to investigate parents' and teachers' perceptions of masculinity development in an all-male private school context, and their views regarding priorities for school-based initiatives designed to support boys toward positive trajectories of masculine identity development. The secondary aim was to uncover potential links with school-based mental health promotion grounded in shifting masculine norms. One overarching research question was addressed: What are teacher and parent perspectives of masculinities in secondary school boys attending an all-male school?

MATERIALS AND METHODS

Design

The study applied a qualitative design using individual interviews to explore the attitudes of parents and teachers toward masculine identity development among boys and young men. Study reporting adheres to the consolidated criteria for reporting qualitative research reporting guidelines (Tong et al., 2007).

Participants and Context

The sample comprised 16 individuals, including 10 parents (six female, four male; all with a son in year 11) and six teachers (three female, three male), from a high-fee independent all-boys' grammar school in Melbourne, Australia.

To contextualize the setting in light of existing scholarship regarding gendered school curriculum, during June 2014-January 2015 the leadership team at the school explored academic evidence regarding biological determinants of learning differences that could be incorporated into the teaching and

learning programs. Among the sources was a synthesis of meta-analyses by Hattie (2008) wherein gender differences in learning styles (comparing boys and girls) concluded "the differences between males and females should not be of major concern to educators. There is more variance within groups of boys and within groups of girls than there are differences between boys and girls" (p. 56). The school's approach to wellbeing-science programs aims to personalize school-based wellbeing by applying a gendered lens to the PROPSER framework for incorporating positive psychology principles in education settings (Noble and McGrath, 2015). This approach aims to do justice to the culturally determined factors (i.e., boys' gender socialization) that impacts mental health promotion for boys and men (Rice et al., 2021), especially in education settings (Salmela-Aro, 2014).

Participants were recruited *via* convenience sampling, but where possible recruitment aimed to include participants diverse in role (i.e., parent or teacher) and age range. This study involved individuals who were recruited as part of a larger study evaluating a school-based rite of passage program for boys and young men (Wilson et al., 2021b), and had indicated their consent to be contacted for future research. The program was a father (or father figure) and son experiential program where participants were encouraged to reflect on their experiences of gendered norms, and, for participating boys, the kinds of men they wished to develop into. All participating fathers and male teachers in this study had participated in the program, and recruitment was also extended to mothers and female teachers in attempt to achieve an even gender distribution of participants. Email invitations that detailed the study description and aims were sent by associated study personnel employed at the school, to parents and teachers. Emails were sent to 38 potential participants in total, resulting in a response and consent rate of 42 per cent. Participants were aged between 32 and 73 years (M = 49.19, SD = 10.35). All participants identified their sexual orientation as heterosexual. Nine participants were born in Australia, and seven were born overseas (United Kingdom = 5, New Zealand = 2). Demographic characteristics of all participants are detailed in **Table 1** below.

Data Collection

Interviews were conducted using a semi-structured discussion schedule that detailed questions designed to solicit insights to address the overarching research question (see **Supplementary Appendix** for full interview schedule). The interview script was drafted and reviewed by the researchers (KG, MW, SR, MS, and RS), who have proficiency in qualitative research and/or the research topics. Key theories pertaining to school-based masculinity development were also drawn upon to guide the framing of interview questions (such as theoretical understanding of the "perception gap" between boys' adherence to masculine norms and their belief that others expect them to conform to these norms; alongside theoretical understanding of masculinities as socially conditioned and learned behaviors that are influenced by context).

Teachers' and parents' perception of the experience of masculinity was gaged *via* questions relating to three topics: being and becoming a young man (e.g., "*Some people think there are 'unwritten rules' about being a man. If you think this is the case, what unwritten rules do you think exist?*"; and the characteristics constituent of "positive masculinity" (e.g., "*What sort of characteristics do you think describes a 'positive masculinity'?*"). Additionally, teachers' and parents' perception of school-based strategies to promote positive masculinities was assessed *via* questions probing the role of the school and potential areas of school-based promotion of healthy masculine identity development (e.g., "*How could the school help students navigate moving from boyhood to manhood in a positive way?*").

Procedure

The study received ethics approval from the University of Melbourne Human Research Ethics Committee (ID number: 1852421), with data collected in November, 2019. Two researchers conducted the interviews (KG and MW). Both interviewers were Research Assistants with BA (Hons) degrees, and prior experience with qualitative data collection and analysis. Participants were emailed the plain language statement and consent form to read and complete before the interview. The interviewer re-established participants' understanding of the study and consent before commencing the interview. Participants' anonymity and confidentiality of their responses were also reiterated to promote honesty and transparency during interviews. Individual interviews were conducted at the school, as a familiar setting for participants (n = 12), or over the phone where participants were unable to attend a session in-person (n = 4). Interviews ranged from 21 to 43 min in duration. The audio recordings were transcribed verbatim by an online transcription service and checked for accuracy by the researchers. After the interview was complete, researchers offered member checking (i.e., the process of re-engaging participants to review and edit their interview transcripts) which was taken-up by one participant with no changes made.

TABLE 1 | Summary of participant demographics.

Demographic	Statistic
Age (range, *M*, *SD*)	32–73 years, 49.19, 10.35
Gender (%, *n*)	
Man	43.8 (7)
Woman	56.2 (9)
Sexual orientation (%, *n*)	
Heterosexual	100.0 (16)
Born overseas (%, *n*)	
Yes	43.8 (7)
No	56.2 (9)
Birth country (%, *n*)	
Australia	56.2 (9)
United Kingdom	31.3 (5)
New Zealand	12.5 (2)
Aboriginal or Torres Strait Islander (%, *n*)	
No	100.0 (16)
Member check completed	
Yes	6.2 (1)
No	93.8 (15)
Role	
Parent	62.5 (10)
Staff	37.5 (6)

Data Analysis

Thematic analysis (TA) was implemented to generate themes in the study data (Braun and Clarke, 2006). Inductive TA was employed by the coding researcher (KG), where analysis was largely driven by the content of the interview transcripts, though data were examined through the coding researcher's disciplinary knowledge of gender and masculinity theories. The findings were advanced conceptually through applying Connell's (1995) masculinities framework as a means to theorizing the findings and connecting with relevant existing research, particularly in terms of masculine hierarchies and hegemonic masculinities. With the research question in mind, the individual interview transcripts were read, highlighting excerpts and making jottings about preliminary interpretations and descriptive labels (186 labels initially) to organize the data. The parent interviews were analyzed using constant comparative methods to distil patterns and diversity within and across participant perspectives. The teacher interviews were similarly analyzed and the patterns compared with the overarching perspectives shared by parents. As the analyses continued codes were subsumed and the descriptive labels were developed to more fully pre-empt the thematic findings. The research team met to discuss their interpretations and consensus was driven both in terms of the weighing of the themes and the illustrative quotes that were used to anchor the findings in the interview data.

Interviewer and Analyzer Characteristics

It is important for interviewers and qualitative data analysts discuss relevant personal information that might inform our approach to interviewing and analysis (Elliott et al., 1999). The lead interviewer and co-data analyst, author KG, is a Caucasian Australian female in her mid-20's. She attended a high-fee co-education high school in Melbourne. To contextualize her schooling experience, she opted to attend a co-education school rather than a single-sex school given public discourse of the perceived environments in single-sex schools. Her research background includes boys' and young men's mental health, masculinity, and mental health in elite sports. Additionally, author MW (co-interviewer and data analyst) is a 27-year-old, Caucasian, gay Australian male. He attended a co-educational independent school in regional Victoria. He approached the interviews and data analysis process with clear awareness of current discourse regarding the potential for single-sex boys' schools to perpetuate traditional embodiments of masculinity, whilst also recognizing the need to promote diversity and difference among school-based masculinities. His research background includes boys' and young men's embodiments of masculinity, and intersections with mental health and help-seeking experiences.

RESULTS

Five overarching themes were generated from analysis of the interview transcripts. These themes are presented in **Table 2**, categorized as influencing factors and strategies for development.

Influencing factors encompasses three themes related to teachers' and parents' perceptions of the state of masculinities for boys and young men. Within this category, themes drew on participants' perspectives about the key gendered influences on male students. Participants commonly offered concessions that some potentially negative influences could not be controlled. Rather the focus was on recognizing the potential for an array of exposures for shaping masculinities in boys. Three themes, *public and private masculinities*, *prevailing Australian masculinities* and *private boys' school culture* were inductively derived to distil the factors influencing masculinity development in greater depth. The final two themes, categorized under *strategies for development*, summarize teachers' and parents' perspectives for prioritizing healthy identity development within the school, which can be in conflict with conventional academic priorities. This was coupled with discussion of practical initiatives to establish a positive developmental trajectory for male students. Across these themes, there was consistent support among parents and teachers for greater educational programming around development of positive masculinities.

Influencing Factors

Public and Private Masculinities

There was a perception amongst participants that the impact of masculine norms can shift depending on social settings and group dynamics. Often, participants would report that when students were alone, they were typically more authentic than when they were in a group setting. It appeared that the nature of social messaging, including where and how boys learn masculine norms, or perceive pressures to act in certain ways relative to the particular context of interaction, could influence expressions of masculinity. The idea that boys and young men need to "*wear a mask*" in order to protect their masculine standing was commonly mentioned; an idea that has clear implications for the exposure of vulnerability needed to facilitate shifting traditional masculine norms in the school context.

> *I think that you kind of do have to wear a bit of a mask at school sometimes to just fit the norms* [Mother, 005]

> *I feel there's a lot of mixed messages that they're getting. . . And what he's picking up on, I'm never quite sure. I mean, his behavior that I see is fine, but I don't know how he is then when he's with his peers* [Mother, 003]

Participants discussed how in a group of males, the loudest voice often dominates to message and manage masculine norms, particularly regarding upholding the hegemonic "tough guy" archetype referenced by Connell and Messerschmidt (2005). Many participants indicated that males who do not conform to, or are complicit in upholding this standard can experience consequences for their wellbeing. Likewise, participants recognized the impact that different social settings can have on boys' and young men's behaviors, for instance in the school relative to the home. As one teacher noted, the school environment is "*a little bit different to society*" [Male teacher, 010].

> *It's a bit of a self-fulfilling prophecy really. That some of them feel that to be accepted and to be the most sort of manly of men, they*

TABLE 2 | Summary of themes with exemplar quotes.

Category	Theme	Exemplar quote
Influencing factors	Public and private masculinities	*I feel there's a lot of mixed messages that they're getting. . . And what he's picking up on, I'm never quite sure. I mean, his behavior that I see is fine, but I don't know how he is then when he's with his peers* [Mother, 003]
	Prevailing Australian masculinities	*Somebody that's admired for his physicalities, his sporting abilities. And often that's where we start with masculinity* [Father, 002]
	Private boys school culture	*I think given the environment, the historical environment of [the school] is not dissimilar to other all boys environments in terms of the culture of the place. I think, like I said, we're at the beginning of a shift* [Male teacher, 016]
Strategies for development	Exposure to positive masculinities	*Having role models and maybe being more clear on these are the behaviors [we want to avoid], and probably be more explicit in that. Sometimes kids don't pick it up, unless you're actually explicit with that language or that behavior.* [Male teacher, 008]
	Transforming masculinities	*He [son] felt it would be really good if [programming] was consistent throughout the time that they were there* [Mother, 003]

need to be on the footy team and they need to do. . . all those sort of traditional male stereotypes [Female teacher, 006]

There's still the hidden expectations of boys with each other, and from their parents having the expectation of their boy which then feeds into the school [Male teacher, 010]

Participants also spoke about the role of the so-called "group mentality" in influencing displays of masculinity by male students, where participants often described first-hand experiences observing students' adherence to traditional masculine norms in group settings. Moreover, participants recognized the flexibility among male students to align with more traditional masculinity norms depending on social context, with a key determinant appearing to be the group nature of the school environment. This may represent a desire among teachers and parents for knowledge of how to encourage male students to feel comfortable enacting positive masculinities, such as disclosing distress or a need for support, irrespective of context.

I think when they get into a group, it's very different. Yeah. That changes the dynamics. They obviously play off each other and they change their behaviors. Whereas, sometimes I'll see a different boy versus a boy in a group [Male teacher, 008]

I think when they get into bigger groups they can fall into those sort of more stereotypical old-school male behaviors. . . And I know all those boys are wonderful and amazing and much more authentic in smaller groups, than large groups [Female teacher, 006]

Prevailing Australian Masculinities

Participants often discussed how Australian cultural norms are incited in the school context, often with reference to traditional, and/or hegemonic masculine norms (Connell and Messerschmidt, 2005). Described were the ways in which sporting culture, the "blokey" archetype of masculinity and male teasing humor can impact students' experiences. Irrespective of whether male students were complicit in sustaining this masculine culture, participants recognized the "sporty young man" as the prevailing norm.

Look, it's a boys' environment, so they're very boysy [Father, 007]

Participants also recognized how the sporting culture in Australia norms athletic achievement, prizes physical prowess, and celebrates success or dominance over one's competitors as idealized hegemonic masculine qualities; a process which according to one father represents an "*unwritten rule around physicality, in a sporting sense*" [Father, 014]. Sports that are perceived as more physically challenging or aggressive (e.g., Australian football or rugby) are favored over sports or other activities that are deemed less so (e.g., badminton, the arts).

You have to kind of engage in the banter. Which would be in Australia primarily banter about sport, so if you're not interested in that, you can't fully participate [Mother, 011]

Even when one does not participate in physically demanding sports, there is an expectation that male students enjoy the spectacle, and express their opinions and authority in discussions about such masculine sports. This echoes Connell and Messerschmidt's (2005) discussion of complicit masculinities as embodied by individuals who sustain such hegemonic norms, even if (and perhaps especially when) they do not fit this archetype. In schools, the sporting "blokey" student is revered; with the superiority of their status regularly appearing to permeate and predominate within the entire school's masculine milieu.

The first thing I learned when I came here was that a lot of the prefects were quite sporty. And then if the prefects that weren't as sporty were seen as quite dorky [Female teacher, 004]

A small number of participants indicated how culturally sanctioned male humor can be instrumental in the construction of "masculine" behaviors. Mentalities necessitating that boys "take a joke" or "join the banter" could be used to excuse poor conduct, or pressure an individual to follow the group in relation to masculine norms. These ideas expose the perceived risk of peer-level consequences for boys and young men who might communicate their individual conflict with these norms.

Because it's that whole pervasive, "Oh, you can't take a joke," mentality. [In] Australian men that is a big problem. [Mother, 005]

Normative humor and jovial behavior among Australian males were recognized by participants as imparting a diversity of influences on males and those around them, ranging from inciting fun and healthy competition to imparting negative consequences for those young men who were perceived as oversensitive and fail to "fit in" with the dominant male archetype within the school. It was implied by some participants that this prioritization of banter could cloud boys' and young men's perception of any warning signs pertaining to mental ill-health in their peers.

> *It can be a great part of being a friend and being a boy and being a man. That playfulness and that banter, but it can also become damaging as well* [Male teacher, 016]

> *There would be boys there who probably weren't even thinking about what they were doing. They were just joining because it was funny* [Mother, 005]

Private Boys' School Culture

Most teachers and several mothers discussed the presence of a narrative regarding the nature of private boys' schools which hinted at the potential risks of this context in the construction of adolescent masculinities.

> *If you listen to the social narrative, there's not a lot of optimism about boys' schools at the moment* [Female teacher, 004]

Whilst participants did not indicate any direct concerns, several interviewees acknowledged questions among the Australian community as to the role of private boys' schools in the potential acculturation of problematic embodiments of masculinity, and the role that this culture can play in explaining reticence toward exposing vulnerabilities *via* help-seeking among boys and young men. Several participants indicated an awareness of how this view can be mirrored by broader society, though believed that it was not reflective of the school's individual ethos or their direct experience.

Whilst enrolling their sons in the school from which participants were sampled was a choice, some parents discussed their initial hesitancy to send their sons to a private boys' school, due to their awareness of concerns perceptions of prevailing masculinity norms that might be perpetuated by this environment. As one father [012] termed it, there was concern around his son getting "*sucked into*" a culture he might not necessarily feel individually comfortable with. From the mothers' perspectives this concern was due to the potential negative impacts of a male-dominated space, whereas for fathers this was attributed to the perceived values of single-sex boys' schools.

> *A boys' school wasn't necessarily what I was going to choose for my kid, because I was worried about the toxic masculinity and the privilege.* [Mother, 005]

> *When he first went to school, he went to a co-ed school. I didn't want him to be like so many of the guys that I work with.* [Mother, 015]

> *My big concern with this school was that it was very sporty. . . So I was concerned that [my son] might get sucked into that, but he isn't.* [Father, 012]

Conversely, some teachers expressed that they felt social concerns around the impact of the private boys' school environment may have been overstated, with one participant stating, "*I think they need to come here for a day and just actually see what happens here*" [Female teacher, 004]. Additionally, some teachers noted the benefits of a single-sex learning environment for boys, including the capacity for certain activities traditionally coded as feminine to become normalized when enacted by male students, highlighting the potential for single-sex schools to simultaneously challenge and reinforce traditional masculinity norms, depending on sub-context.

> *I think it's actually easier in one way to break down that mold at an all-boys school. It creates the space. There's a lot of kids involved in drama, they actually get really passionate about it and arts and stuff.* [Male teacher, 010]

Strategies for Development

Exposure to Positive Masculinities

Participants indicated that they valued the opportunity for male students to be exposed to varying embodiments of masculinity, in terms of role models and *via* varied learning experiences in order to provoke internal exploration and self-determined identity development. Reflecting a degree of awareness of some of the core tenets of gender justice (Lingard and Douglas, 1999; Keddie, 2006), some participants voiced the importance of normalizing certain stigmatized traits or behaviors among males, such as expressing emotions, seeking help, and disclosing distress. This was supported both within and beyond the school context.

> *If you can set the container right and boys can share and they can realize, "Oh it's okay to feel like that." Or they feel like that too. That's normalizing, expressing your feelings and stuff like that* [Mother, 005]

> *It is changing [sensitivity as a sign of weakness] as there is a greater awareness and honesty. And that comes with, I think, seeing more and more examples of people that are prepared to discuss challenges more openly.* [Father, 014]

Exposure to masculine role models that could serve as a circuit breaker to provide exposure beyond the microcosm of the private boys' school environment was seen as a key mechanism through which boys might experience and learn the normalization of certain behaviors and qualities traditionally coded as anti-masculine.

> *It's very difficult because his environment at the moment is his family and his peer group, et cetera. He meets other people when we give him other experiences, but that's fundamentally his world at the moment.* [Father, 007]

> *I think maybe a bit more genuine community impact. And that has an important role to play in boys understanding that there's more outside of going to a privileged school* [Mother, 015]

Strategies that were desired within the school included leveraging role models, such as senior students, staff and community members, who can model healthy embodiments of masculinity, alongside the need for space in the curriculum for novel and reflective learning experiences. Additionally,

notwithstanding the lack of consensus among participants regarding what constitutes positive or healthy masculinities, or exactly what a healthy male role model might look like, parents and teachers consistently reported an appetite for greater intervention and educational programming within the school to encourage development of healthy masculine identities.

> *The more we could do for boys in school to have these conversations and offer an alternative viewpoint from the thinking that they're probably used to thinking is only going to be a good thing* [Mother, 005]

> *I think what the school needs to give is as many opportunities as they possibly can so that the boys can sort themselves out.* [Father, 007]

> *I think you've just got to keep showing a diversity of different. like, the right behaviors in a sense. That's, I suppose, going to come to an agreement of what the right behaviors are* [Male teacher, 008]

Furthermore, participants valued opportunities for boys to develop autonomy and independence. It was noted by one father that future efforts by schools should aim to provide encouragement toward healthy identity development, without forcing boys to take any given path, such that this can be a self-determined process.

> *There's a certain degree of freedom that's allowing boys to now take their own path. I think that there's a nice progression there from here's what we're expecting through to now we're watching you, to not watching you, but we're giving you the freedom to go and express that and make your own decisions.* [Father, 002]

Transforming Masculinities

Equally expressed in discussions regarding social contexts, participants discussed the shifting and varied messaging boys received in school. Notably, parents indicated a marked shift from early high school, where there had been more space to focus on masculinities and identity development, to late high school, where the focus shifted largely to prioritizing academic achievement. The lack of focus on positive identity development in the last 2 years of school was perceived to detract from the school's ethos, ostensibly reducing the focus on holistic identity development in favor of academic success. It was important to parents that the focus on healthy masculinities and identity development remain constant across all year levels in the school, and that learning opportunities were relevant to each year level's needs and current gendering experiences. Such perspectives imply the need for mental health promotion efforts that span early- to late-high school, such that healthy and positive embodiments of masculinity can be consistently and longitudinally reinforced.

> *But then next year, I guess he's just going to spend the whole year fixating on exams.* [Father, 012]

> *He [son] felt it would be really good if [programming] was consistent throughout the whole time that they were there* [Mother, 003]

Encouragingly, teachers commonly noted how the school's culture had shifted toward holistic development and healthy masculinities in recent years, alongside the importance of consistently expressing that ethos to students and the community.

> *The school has transformed and the messages it gives to the boys consistently and it's deep rooted in our whole ethos and this school is very different and very powerful.* [Female teacher, 009]

Participating teachers also appeared to take pride in the fact that they were offering an environment to boys and young men wherein their success is defined not purely in terms of academics, but also in the extent to which students develop qualities characteristic of a "good man."

> *It's changing a bit because schools put some outward facing stuff to say that, actually if you send your son here, we're going to be focusing, we will have some focus on their wellbeing, on mindfulness at times, on a proper healthy identity* [Male teacher, 010]

> *I think we've even taken the word successful out of a lot of our vocabulary at school. So we talk about being a good man rather than being a successful man* [Female teacher, 009]

DISCUSSION

The aim of this study was to explore parents' and teachers' perceptions of masculinity development in an a single-sex independent school context, and their views regarding priorities for school-based developmental programming designed to encourage healthy expressions of masculinity, to inform mental health promotion interventions. The first three themes, categorized as *influencing factors*, detail teachers' and parents' views on the nature of masculine identity development and performance in the school context. Commonly noted was the difference between so-termed public and private masculinities (Hearn, 1999), where often the single-sex school context can serve to facilitate the group-level adherence to traditional masculine norms. Additionally, the latter two themes were categorized as *strategies for development*. Teachers and parents noted the importance of boys' exposure to positive masculine role models. Finally, the prioritization of activities and programming supportive of positive masculine identity development was perceived by parents to be in conflict with the focus on academic success during latter years of schooling.

Influencing Factors

Results highlighted that participants were acutely aware of many of the mechanisms underpinning the reinforcement of specific traditional masculinity norms, discussed by Connell and Messerschmidt (2005) as indicative of hegemonic masculinity, such as sporting prowess and emotional restrictiveness within the school context. Teachers and parents frequently commented on the disconnect between public and private masculinities, and in order for boys to fit in at school, they must adopt a "mask" that is complicit in sustaining normative behaviors within the all-boys school context. These norms included sporting prowess and "blokey" teasing humor; discussed in prior work exploring "laddish" cultures among boys at school and the extent to which these codes of behavior problematize engagement with

schoolwork (Jackson, 2010). Notably, most participants also recognized that masculine norms were most likely to intensify, or exaggerate, in group situations. A theoretical explanation is offered in precarious manhood theory, which posits that manhood is a status that must be continuously and visibly demonstrated and defended (Vandello et al., 2008). Boys may exaggerate socially gender-typical behaviors when their actions are visible to (and likely judged by) their peers. This finding also accords restrictive masculinities detailed by Reigeluth and Addis (2016), in terms of a policing of masculinity, which serves as instrumental in the gender role socialization of boys and young men at school.

Notwithstanding participants' perception of the dominance of certain masculine norms within all-boys' schools, inherent in their discussion of public and private masculinities is the understanding that boys and young men *can* be flexible in their adherence to masculine norms. One example of this is the perception of normalization of behaviors traditionally coded as "feminine" within the all-boys school context, such as drama and engagement with the arts. Keddie (2006) discusses the imperative of allowing boys opportunities to broaden their enactment of masculinities in school contexts, and facilitation of engagement with traditionally non-masculine pursuits is an important vehicle in this process. Notwithstanding this, perhaps all-boys school environments represent a particularly salient force that polices adherence to traditional norms; yet in spite of this, parents and teachers understand that often behaviors reflecting these norms can represent a state-based means to prove one's masculinity to peers, rather than being indicative of fixed behavioral traits. These perceptions of group-level upholding of masculine codes of behavior were also observed by teachers interviewed in Jackson (2010, p. 507), where teachers reported boys' and young men's adoption of a "pack mentality." Echoing established scholarship regarding how gender justice can be advanced in schools (Keddie, 2006), such findings speak to the value of group-based interventions for boys and young men, where space can be provided to expose the power and policing of peer expectations for their embodiments of masculinity (King et al., 2021; Rice et al., 2021).

This idea has been implemented in previous gender-transformative programs focused on help-seeking intentions for suicidality (Calear et al., 2021), and reducing support for the use of violence in relationships (Banyard et al., 2019). Past research has found evidence of a disconnect between that which boys and young men believe individually and what they anticipate their friends believe concerning expected masculine behaviors (Irvine et al., 2018). Building on this, recent theoretical work has also operationalized positive masculinity, with authenticity as a key component (Wilson et al., 2021a). The tension between public and private masculinities has also been reported in prior research with high school and tertiary student young men (Reichert, 2001; Edwards and Jones, 2009). This can be viewed as a conscious self-fashioning, where boys may purposely adopt a public persona that aligns with the acceptable performances of masculinity in the school (Kehler and Martino, 2007). Prompting male students to interrogate how and why their behaviors or attitudes oscillate between contexts may promote a shift to more consistently authentic behaviors, unimpeded by restrictive and fixed gender norms. As such, facilitating an environment for boys to critically reflect on their behavior and understand the extent to which the norming of certain behaviors can be helpful or harmful, is important to helping boys establish a self-determined, prosocial masculine identity. There are current efforts underway to evaluate programs seeking to achieve this end (King et al., 2021).

Whilst these findings reinforce the value of group-based mental health promotion interventions grounded in shifting masculine norm adherence, the acute awareness among parents and teachers of the mechanisms underpinning reinforcement of traditional masculinities, signals opportunity to more directly involve parents and teachers in reinforcing the group-based learning imparted *via* such programs. Indeed, some comments from fathers in particular appeared to standardize the existence of masculine norms within the school context (e.g., "*look, it's a boys' environment, so they're very boysy*"). This potentially signals a sense of perceived intractability of school-based masculinity norms among some parents (particularly fathers). However, fathers also expressed concern about their sons getting "*sucked in*" to a culture of masculinity with which they did not necessarily agree. These results have implications for school-based initiatives aiming to shift masculinity norms, as it is clear that there is scope to upskill parents, particularly fathers, in their capacity to model healthy masculinity norms at home to reinforce any messaging imparted *via* school-based intervention. Past research aiming to improve youth mental health has involved parents *via* improving their mental health literacy in attempt to model positive attitudes toward help-seeking and the norming of mental health challenges, particularly in adolescence (Hurley et al., 2018). Yet given the instrumental role of fathers in modeling masculinities (Fellers and Schrodt, 2021), there is potentially scope to develop complementary home-based initiatives for families, such that any gains in shifting masculinity norms in relation to mental health and promotion of help-seeking at school, are carried through at home.

Conversely, given that sporting prowess is prized masculine capital within school contexts, there is also scope to more directly involve a range of teachers in programming to promote a diversity of perceived masculinities among students. This is important in light of the role physical education teachers can play in inadvertently perpetuating masculine norms, particularly regarding male teachers (White and Hobson, 2017). Given exposure to positive role modeling was a desired development strategy among participants, future research may seek to uncover ways in which parents and teachers can congruently occupy role model positions in their everyday actions with sons/students. This call is also reflected in the 2021 Insights Report from the *Man Cave* program: a school-based workshop-style intervention for boys and young men focused on deconstructing masculine norms as a means to promote mental health (Defina et al., 2021). Specifically, facilitators communicated that it is "critical [we parents] look at our own actions and words and ensure they align with the messages we're trying to pass onto [boys and young men]." This might be an important avenue to bolstering gains made *via* student-level interventions promoting healthy

masculinities in the context of an all-boys school, where peer-level policing of masculinity expression is thought to be most salient (Kirk, 2000; Kehler and Martino, 2007); particularly in all-boys schools (Kirk, 2000).

Strategies for Development

School-based health promotion programs targeted for boys and young men increasingly incorporate a focus on reducing adherence to traditional masculine norms, by offering group-based activities designed to encourage reflection on links between masculinity norms and mental health and behavior (Banyard et al., 2019; Claussen, 2019). Yet foremost among our participants was a desire for boys and young men to have greater exposure to positive masculine role models. The perception was that this could short-circuit negative psychosocial development and help boys to appraise a positive masculine blueprint to strive toward. Whilst gender-transformative developmental programming is increasing in implementation (Gwyther et al., 2019), and role modeling of help-seeking masculinities was incorporated in the *Silence is Deadly* program (Calear et al., 2017), there is a sparsity of academic research exploring the direct effects of positive role modeling on masculine identity development among boys and young men. One qualitative study addressing emotional mentoring relationships between male youth and adult men highlighted potential for facilitating flexibility in the enactment of masculinity norms such as self-reliance and emotional restriction (Spencer, 2007). Research has also highlighted that children's perceptions of fathers' embodiment of traditional masculinity is linked to reduced father-child relationship closeness and satisfaction (Fellers and Schrodt, 2021). There is a dearth of research that explicitly articulates masculine role models that might facilitate boys' and young men's adoption of positive masculinities, and by extension, promote mental health behaviors. For example, future research could explore whether a positive masculine role model should embody the inverse of so-termed "toxic" masculinities (Ging, 2019), or whether *both* the embodiment of positive masculinity (Wilson et al., 2021a) and critical reflection on the harmful nature of traditional masculinities is required to facilitate boys' and young men's mental health. Further research is also needed to understand how to effectively implement positive role modeling for boys and young men in order to achieve lasting change, given a specific focus on father-son dyads appears scant in the available literature.

Furthermore, results demonstrated a slight disconnect in the extent to which teachers and parents see healthy masculine identity development prioritized in tandem with academic success at school. Some developmental programs for boys and young men have involved parents (Wilson et al., 2021b), yet further research is needed to clarify parents' expectations around how best to support both positive identity development ventures alongside academic outcomes. This is especially important given past evidence of the perception among teachers that boys and young men prize and prioritize their masculine social standing through the rejection of academic priorities (Jackson, 2010). There is therefore the risk that, without involvement of parents and teachers in cohesive efforts to shift adherence to masculinities, both academic engagement and healthy masculine identity development will be trumped by boys jockeying for peer-group social standings within traditional masculine hierarchies and collectively protesting subordinate student status.

LIMITATIONS

To our knowledge, this is the first study to provide an in-depth examination of the perspectives of parents and teachers on school-based masculinity development and avenues for improvement in school-based developmental programming. Several study limitations nevertheless require acknowledgment. Firstly, the focus on one school and a relatively small participant sample limits the generalizability of the results, especially considering results pertaining to parents who had the means to choose an independent high-fee school for their sons. The concept of a school-based intervention designed to promote help-seeking *via* shifting masculinity norms is itself an initiative that has thus far primarily been studied among schools with the resources to implement such programs alongside established programming. As such, the extent to which these results generalize to families associated with less-resourced schools is limited and democratization of this work is needed. Additionally, the nature of the sampling may have limited perspectives to those who were interested and invested in the study area; those that did not respond to the email invitation may hold differing opinions than those identified in this sample. Similarly, participant characteristics may be reflected in the results, namely, the focus on Australian culture could have emerged due to the large percent of participants who were born in countries other than Australia, where differences between countries may be salient. Additionally, as all participants identified as heterosexual, the present findings should be considered in the context of a heteronormative view of masculinity, with potentially limited applicability to sexual minority parents and teachers. We also acknowledge that we approached the analysis from a predominately *cis*-heteronormative view of masculinity. Whilst this helps to understand the results in terms of existing scholarship in the field that also adopts this frame, there is an inherent risk that continuing to apply this lens limits the necessary exploration of diversity and difference in masculinities that is needed to advance gender justice efforts more broadly, and norm embodiments of masculinity beyond the traditional frame. A limitation also concerns the transparency of participants' responses. For parents, they might have pre-empted judgment from the interviewer or the research team, particularly concerning their discussion of decisions regarding sending their child to an all-boys school in light of societal discussion regarding the role of this environment in the potential acculturation of harmful embodiments of masculinity. Whilst there was no direct evidence of any censorship occurring during interviews, it is nevertheless a possibility and should be considered when appraising these results. A similar caveat concerns participating teachers.

TABLE 3 | Recommendations for future research.

Category	Recommendations
General recommendations	More diverse participant sampling to allow explorations between masculinities, mental health promotion and other social subgroup memberships (i.e., race, class, gender, sexuality).
	More direct exploration of links between masculinity norms, help-seeking and mental health symptom profiles (e.g., whether masculinity carries differential influences on help-seeking for anxiety relative to suicidality), and how programming to promote positive masculinities can apply across symptom profiles.
Influencing factors	Qualitative research with parents and teachers to better understand their (inadvertent) role in perpetuation of traditional masculinity norms per-context, particularly in relation to mental health and help-seeking.
	Qualitative group-based research with boys and young men to better identify the specific contexts and social mechanisms (e.g., the "perception gap") that lead to perpetuation of traditional masculine norms, even when this is not conducive to wellbeing.
	Co-design curriculum for parents and teachers that complements programming for boys and young men, focused on modeling healthy embodiments of masculinity, alongside promoting reflection on inadvertent reinforcement of traditional masculine norms.
Strategies for development	Further research to define the characteristics of "healthy masculine role models" and explore the kinds of exposure needed (e.g., story-telling, experiential programs) to achieve positive benefits to promotion of positive masculinities among boys and young men.
	Work with school leadership to explore implementation avenues for promotion of school-based positive masculinities alongside, but not at the expense of, academic pursuits at school.

FUTURE DIRECTIONS

Future research directions arising from our results have been summarized in **Table 3** below.

Foremost, future studies should aim to sample participants from varied settings, including rural, co-educational, and moderate to low socio-economic status schools. Such research will allow exploration of the intersections between masculinity and race, sexuality, economic status, and culture. Accurate and diverse representation of the current masculinized experiences of boys and young men will ensure future initiatives are aligned with the needs of particular sub-populations. This is particularly important concerning the experiences of boys identifying as transgender or non-binary masculine, where the gendered structure of an all-boys school is likely to give rise to particular effects on identity formation and mental health. Additionally, future research implementing programs such as *Silence is Deadly* and other initiatives focus on shifting embodiment of masculinities, would do well to more directly explore the extent to which these programs are shifting masculinity norms, and how peripheral parties such as parents and teachers can be involved in these programs to facilitate consistent messaging across contexts. Additionally, whilst existing programs have broadly focused on reducing adherence to traditional masculine norms as a conduit to promoting help-seeking in the context of suicidality, more direct exploration of links between masculine norms, likelihood of help-seeking, and different mental illness symptom profiles is needed. For example, the extent to which self-reliance interacts with anxiety relative to depression in reducing likelihood of help-seeking remains largely unexplored.

CONCLUSION

The varying impacts that schools can have as an agent in, or site for, the production of masculinities were highlighted in the perceptions of the teachers and parents. The impact of social contexts, cultural norms, and community narratives were prominent themes in the interviews. Understanding these factors, participants identified key strategies to promote healthy masculine identity development within and beyond the school context. Notwithstanding this, there is clear scope for greater involvement of parents and teachers in the aspects of health promotion interventions that rely on and reflect healthy expressions of masculinity. If we are to assume health promoting outcomes for boys and young men are mediated by embodiment of prosocial masculine norms, then accounting for and involving *all* agents of influence in this process would be an advantageous step toward bolstering the potential wide-ranging benefits.

DATA AVAILABILITY STATEMENT

The datasets presented in this article are not readily available because provision of original data was not stipulated in the ethics approval for this study. Requests to access the datasets should be directed to SR, simon.rice@orygen.org.au.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by The University of Melbourne Human Research Ethics Committee. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

MW led manuscript drafting and contributed to data collection and analysis with KG. MS supported data analysis and the manuscript revision. RS led funding acquisition, and supported study conceptualization and the manuscript revision. JO guided data analysis and manuscript revision. KC supported data collection and contributed to the manuscript revision. SR supervised all aspects of the study, supporting data analysis, and the manuscript

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Emotional constraint, father-son relationships, and men's wellbeing

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Male rates of suicide exceed female rates and research findings indicate an association between particular practices of masculinity, specifically emotional constraint, and male suicide. This paper examines gender and family influences on men's wellbeing, based on in-depth interviews with a sample of fifty-two men, aged 18–30 years, who made a clinically serious or near-fatal suicide attempt and were recruited following presentation to hospital. Themes derived from the analysis included *learning about masculinity* which relates to the gender culture within the home, *the regulation and enforcement of behavior by peers* and *father-son relationships*. Results demonstrated that the men were generally from families where hegemonic ideals of masculinity, emphasizing strength and emotional stoicism, were practiced. This gender environment, which was reinforced in the neighborhood, restricted behavior and the expression of feeling, shaped communication between fathers and sons and affected the father's ability to emotionally engage with his son. Fathers were significant figures in these men's lives and were role models for demonstrating masculinity practices but there was an absence of positive, nurturing, relationships between fathers and sons and this influenced the son's gender learning and his wellbeing. Fathers who were emotionally distant, and particularly those who were abusive, gave rise to feelings of rejection, sadness and anger in their sons but problematic father-son relationships were not addressed nor ill-treatment in childhood disclosed due to gender-related constraints on expression. Restrictions on expression and prohibitions on revealing weakness denied the men a space to explore as well as manage the issues of their lives and prevented them from revealing distress. They coped by sublimating problems and disguising vulnerability and by seeking emotional comfort within intimate partnerships but these men were susceptible to situations which threatened their psychological security. Overall, the study demonstrated challenges for males raised in settings of hegemonic masculinity and the importance of nurturing father-son relationships for male wellbeing. The results imply the need for a focus on the benefits of positive fathering and the inclusion of more nuanced messaging relating to men's emotions in Public Health messaging.

KEYWORDS

masculinity, emotions, emotional constraint, suicide, men's health, fathers, fathering, childhood trauma and adversity

Introduction

High levels of male, compared to female, suicide exist in Europe and the United States although male suicide rates vary across as well as within countries, based on cultural and socioeconomic factors (Cleary, 2019; World Health Organisation, 2014, 2019). A gender explanation has been suggested for the high prevalence of suicide amongst men in Western societies and linkages have been identified between practices of hegemonic masculinity, particularly emotional restriction, and male suicidal behavior although the detail of this association is unclear (River and Flood, 2021). The aim of this analysis is to explore how particular cultural environments affect gender and wellbeing by focusing on the influence of the family and the father on the son's practice of masculinity.

Individuals acquire ideas about gender within a particular cultural setting and this provides the broad script which the male draws from when negotiating his behavior and his emotional life. These gender concepts are introduced at an early age and generally maintained by surveillance from family and peers (Kimmel, 1994). The expression of feelings is gendered, more rigidly so in some cultural environments, reflecting a belief that men and women have different emotions, that these emotions are natural or innate and channel males and females into various forms of behavior (Shields, 2007). The regulation of emotions can impact negatively on mental wellbeing and create a risk of suicidal behavior (Cleary, 2019). The binary division of emotions is associated with practices of hegemonic masculinity, a way of performing manhood that emphasizes strength and discourages behavior or displays of feelings which imply weakness (Kimmel, 1994; Connell and Messerschmidt, 2005). Hegemonic masculinity is the idea that a dominant, socially constructed, form of masculinity is given preference over other expressions of masculinity and femininity (Connell and Messerschmidt, 2005). Men are not a unitary group and male/female differences relating to behaviors and emotions are, in reality, more fluid (Simon and Nath, 2004; Patulny et al., 2017) yet, oppositional gender concepts and unitary notions of men and male emotions underline much suicide-related research. This analysis is part of a study (Cleary, 2019), which adopted an alternative research direction, in the tradition of Douglas (1967) rather than Durkheim (1951), that sought to explore male suicide from a social constructivist perspective, by allowing the subjects to relate their own stories around suicidal action. Within these self-constructed narratives childhood, fathers, and father-son relationships featured prominently and while these topics have emerged in other work related to male suicidal behavior (Wagner et al., 2003), they remain relatively underdeveloped in the research literature. This analysis focuses on family and peer influences on gender performances, the contribution of the father to the man's practice of masculinity and the implications of these elements for his wellbeing.

The family and fathers contribute to gender learning and emotional wellbeing in their sons in various ways. Fathers are the usual gender models for young males and the way the father engages with his son and demonstrates masculinity influences both the son's gender-related behaviors and his wellbeing (DeFranc and Mahalik, 2002; Adamsons, 2013). The father's involvement and his ability to develop a nurturing relationship with his son has important consequences for the child's psychological development (Lamb, 2010; Adamsons and Johnson, 2013) and problematic father-son relationships can have negative psychological implications for males (Wagner et al., 2003; Videon, 2005; Bronte-Tinkew et al., 2006). Males who have close relationships with their fathers are more likely to be open about problems and to develop enduring relationships and friendships with others, including other males, while negative father-son interaction is associated with deficits in forming relationships, poor self-image and psychological problems including suicidal behavior in males (Gould et al., 1996; Fergusson et al., 2000; DeFranc and Mahalik, 2002; Johnson et al., 2002; Wagner et al., 2003). Fathers with traditional views of gender tend to have less positive relationships with their children (Smyth and Russell, 2021) and fathers who adhere rigidly to hegemonic masculine values are less likely to have close relations with their sons (DeFranc and Mahalik, 2002). Moreover, the parenting styles of fathers tend to be transmitted to sons (Brown et al., 2018; Jessee and Adamsons, 2018). The gender and relational environment within the home and specifically father-son relationships are therefore relevant for the growing boy's wellbeing and the existence of difficulties within the family, such as physical and or emotional abuse, adds complexity to this situation.

Childhood trauma appears to have a particularly negative impact on males as the risk of suicide is higher for males than females in these circumstances (Dube et al., 2001; Wagner et al., 2003; Afifi et al., 2009; Weich et al., 2009). Those who die by suicide are significantly more likely to have experienced ill-treatment and traumatic events in childhood and the probability of suicide increases with the nature and extent of the negative experiences (Dube et al., 2001; Molnar et al., 2001; Enns et al., 2006; Seguin et al., 2011; Giupponi et al., 2018). Children who face adversity usually experience distress but long-term psychological outcomes are dependent on the ability of the child to access support (Dube et al., 2001). Gender cultures which feature emotional restriction for males may prevent disclosure of these experiences and there is evidence to support this from studies which show that males who suffer childhood abuse commonly use coping strategies such as denial and emotional suppression, misuse alcohol and drugs (Afifi et al., 2009; Hughes et al., 2017) or become involved in violence (Moreira et al., 2020). Males raised in traditional or hegemonic home environments have a higher risk of suicide (Afifi et al., 2009) and it appears that men in working-class settings are more likely to affirm this type of masculinity (Joe and Kaplan,

2001) and manage their behavior and emotional performances in line with hegemonic practices (Cleary, 2012, 2019; Mikorski and Szymanski, 2017). Working class males have comparatively high rates of suicide and studies have shown how economic disadvantage contributes to suicide risk *via* higher exposure to adversity (Turner et al., 2006) and reduced life options (Redley, 2003). In this paper I explore how gendered environments, negative relationships with fathers and traumatic experiences affected the lives of men who attempted suicide.

Methods

The aim of this research study was to understand suicidal action from the perspective of men who attempted to take their own lives and to explore the background circumstances and motivations involved. This social constructivist approach was prompted by the author's theoretical position and by a relative scarcity of data based on this method. The focus of this paper is to explore the impact of exposure to hegemonic ideals and practices, including restricted emotional expression, on men who made a suicide attempt in adulthood and the influence of fathers and father-son relationships within this gender scenario. The analysis is based on interviews with fifty-two men who made a clinically serious or near-fatal suicide attempt.

Sample and data collection

Inclusion criteria included gender (male), age (18–30 years) and high level of severity and intent in that all those included in the study had made a serious suicide attempt with definite intent to die. The age and gender criteria were chosen to reflect a population group with a high rate of suicide in Ireland and other Western countries. The interviewees consisted of a consecutive sample of 52 men from three hospitals in the Dublin area and involved all those who presented to these hospitals over a specific time period who fulfilled the study criteria—males aged 18–30 years who had made a clinically serious suicide attempt. Two of the hospitals are district hospitals (with major Accident and Emergency and psychiatric units) and the third a psychiatric unit, which admits patients from a nearby general hospital (the hospitals cannot be named due to confidentiality requirements). The sample can be regarded as representative due to the seriousness of the attempts and because these hospitals were likely to receive all such admissions from this area over the period of the study. Participants were referred by the liaison psychiatrists working in the Accident and Emergency Departments of the hospitals. One man refused to be interviewed. The high response rate was achieved, I believe, primarily because these men wanted to talk about this critical event in their lives and I presented an opportunity for them to do so. A common reaction from the men when asked to participate was that they were glad to do so in order to help others in similar circumstances. There was strong support from hospital personnel for the research and clear lines of communication established (including a designated contact person in each center) prior to commencement of the study. This followed extensive negotiations with the hospitals relating to ethical, access, and procedural issues prior to permission being granted for the research project. The fact that I was a woman may have been a positive factor as it emerged that, for these men, speaking about personal matters with a female was not as proscribed as relating in this way to a male. In addition, I was an experienced interviewer, able to listen and cope with strong emotions as well as silences. I was also genuinely interested in what they had to say.

The participants were interviewed, by the author, as soon as possible after the suicidal action, depending on the extent of their injuries. An unstructured interview schedule was used in the session consisting of one introductory question "Can you tell me how you came to be admitted here?" Thereafter, no further pre-set questions or topics were covered but prompts were used and questions asked in response to issues raised by the respondent. This approach was adopted in order to avoid pre-categorization of the suicidal action or motives and to allow the respondent to tell his story in his own way following in the tradition of Douglas' (1967) work. A common feature at the start of the interviews was a verbal outpouring after this initial question and in almost all cases they developed the narratives themselves and required little prompting. Common topics emerged which was understandable as they shared a very specific experience, i.e., the suicide attempt. Their initial narrative was usually about the lead-up to this event and this generally led on to background and family issues. The theme of fathers and relationships with fathers, which is a focus of this paper, emerged spontaneously and was not included on any topic. Prompting when it occurred was usually quite general, for example, "tell me about that" when they raised an issue (there are examples in the current text of these questions and prompts), and as the fieldwork progressed I asked a small number to tell me about their family if they had not mentioned this. Interviews lasted ∼1 h, but some were considerably longer and were audio-taped. All but two men agreed to this and in those cases I took notes which I wrote up following the interview. I also recorded notes and observations on the interviews after each session including tracking my response to the session and the subject. The majority of the interviews could be classified as successful encounters as there was a good level of engagement between us and the respondent appeared relatively relaxed but this was not always so. Two interviewees became hostile as the sessions progressed and there were instances when distasteful opinions or violent actions were described which were difficult to listen to. The interviewing style was informal with an emphasis on listening but this does not imply uncritical acceptance of their accounts. My position was that of an academic researcher from

a university and I stated this verbally and in the consent form as well as emphasizing that I had no connection with the study hospitals.

Data analysis

The interview tapes and field-notes were transcribed and the analysis carried out *via* computer and manual methods. The data were analyzed using a modified version of grounded theory (Corbin and Strauss, 2014) guided by Douglas's (1967) methodological approach to this topic of enquiry and Connell's (2010) life history analysis. I listened to the tape following the interviews and read all transcripts and field-notes on an ongoing basis to obtain a comprehensive picture of the data. From the beginning, narrative patterns emerged—not surprisingly related to explanations for the suicidal behavior and the way in which the suicidal pathway developed. Other themes which emerged concerned family background and relationships, enduring emotional anguish and restrictions on disclosing distress. I then used a computer program for qualitative data analysis (NUD*IST) to identify frequently occurring words and phrases linked to these themes. I also produced a summary note relating to each participant based on the transcript and field-notes. Following this I re-read the transcripts, field-notes and individuals' summaries continually to establish themes. I then examined relevant literature and moved back and forth between the literature and transcripts to develop the thematic analysis. Theoretically the analysis was driven by a social constructionist framework and by the work of masculinity writers such as Connell (2005, 2010). The present paper focuses on topics relating to family background and relationships with fathers which represent a re-analysis and elaboration of issues already reported (Cleary, 2019). Three main themes were derived from this re-analysis of the data. The first theme (*learning about masculinity*) relates to the culture of masculinity the men were exposed to growing up, the second theme (*the regulation and enforcement of behavior by peers*) concerns the influence of neighborhood and peers and the third theme (*father-son relationships*) refers to father-son interaction and is divided into subthemes, *seeking love and care from the father, rejection by the father* and *violent fathers*. In writing up I have referred to the men's life stories and have used verbatim quotations to stay as close as possible to the meanings contained in their own accounts.

Ethical considerations

Approval for the study was obtained from the hospitals' ethics committees. Before referral, the man was informed about the study, advised that the project was independent of the hospital and his treatment regime and that participation was entirely voluntary. When I met the potential participant, I explained the nature of the study in greater detail, answered any questions and again emphasized the voluntary, confidential, and independent (of treatment) aspect of participation. After this process was completed the man signed a form, developed in co-operation with the Ethics Committees, giving his consent to participate in the study. Participants therefore had a number of opportunities to decline an interview which represented an important safeguard for them at a vulnerable time. The data was anonymised, cleaned of all identifying features, before it was removed from the hospitals and the list of participants, to which only the author had access, was kept in a locked environment in the university and destroyed at the required time. Pseudonyms are used in this paper and all identifying features have been removed.

Results

The aim of this study is to explore the impact of exposure to hegemonic ideals and practices, including restricted emotional expression, and the influence of fathers and father-son relationships within this gender scenario. The first theme (*learning about masculinity*) derived from the data concerns the culture of masculinity and emotional expression these men were exposed to growing up which shaped their ideas about gender and indicated acceptable practices for males. A related theme (*The regulation and enforcement of behavior by peers*) deals with the influence of neighborhood and peers in terms of conformity to hegemonic practices. The third theme considers the influence of the father on the man's practice of masculinity and the implications of father-son relationships for both gender performance and wellbeing and this is subdivided into key aspects of father-son relationships which derived from the data-*seeking love and care from the father, rejection by the father* and *violent fathers*.

Learning about masculinity

The men in this study were mainly from lower socioeconomic backgrounds and the home was an important site for acquiring ideas about masculinity and receiving guidance on how to behave and to express oneself. Fathers were significant figures within this system and in the men's lives, whether fathers lived within or outside the home, and were often cited as role models or reference points against which the men compared their own performance of masculinity.

> *My dad is everything to me. He's one of those people really I can look up to. He made himself into what he is and he's just great. . . . God knows I've tried but I'm not his son at all, because his son would be able to go out and do that. That's*

> *what my father would do, not what I'm doing. . . . You follow in your father's footsteps and you'll be better. If I was to follow his footsteps, be the man he is, be the husband that he is to my mother and be the father that he is to us I would be. . . . . . that's what you want and it's a horrible thing when you want something and you can't have it.* Alex

The form of masculinity evident in their families was generally traditional or hegemonic in terms of values and behavior and the father tended to occupy an authoritarian position in the household.

> *He was a hard man to grow up with. He was strict, always had that in him. If you crossed him obviously you paid the price.* Matt

The father was instrumental in imparting and enforcing ideas about masculinity and, in line with hegemonic ideals, sons were guided from an early age to avoid signifiers of vulnerability.

> *I learned from an early age from my father that having problems is not a good thing to have. Well, just things that happened to me. I remember one time I got moderately upset about something and my mother and my mother's friend were being all mollycoddling to me and my father thought this was absolutely a big laugh, disgraceful, so he just gave me a look of severe disgust and embarrassment that I had been allowing myself to be mollycoddled by females. I was about eight or something.* Nicholas

As Nicholas implies, there was an awareness from a young age of distinct behavioral and expressive norms for males and females and that feelings had to be managed according to these binary gender lines. Interaction between males in the household differed from that between mothers and sisters and mothers overwhelmingly did the emotional work in families. Fathers were generally viewed by participants as emotionally distant and communication between males in the household rarely diverged from discussion of impersonal topics. Matters outside this narrative sphere were ignored or dealt with *via* teasing or "slagging" which the participants recognized as a way of avoiding emotional intimacy and uncomfortable topics. Gender conformity was expected and behavior set out by the father was reinforced by other males within the family as demonstrated by Alex's account of interaction within his family.

> My brothers tease me and all like that. In a way they upset me because me da says "well they're your brothers and that's what your brothers do". But yeah, they're my brothers but they know it upsets me. I generally really just can't take a joke. I could before but now it's like I'm looking for an excuse just to show (anger). . . .I talk to my brothers and I talk to my da. They thought I was just being too much of a whinger which I was. I was still whinging about it. They were joking and having a laugh but they didn't really realize the extent that I don't want to deal with that. They are supposed to love me. And they do. I know they do but I was twisting it and everything. I was trying to make something bad out of it.
>
> ***When you told your dad about the teasing, what did he say?***
>
> "Stop whinging". Stop your moaning about it and he was right and I should have because they all mess with each other. . . .We're a very close family and that's what makes it very hard as well. I think the fact that we're so close makes it really hard. Because we're so close you hurt people even more.

There was generally no outlet within the home to discuss feelings outside these gendered parameters and signifying weakness was discouraged. Even when vulnerability was uncovered it did not appear to disrupt these practices of masculinity. Leo, who was the youngest in the family, portrayed his relationship with his father as emotionally distant ("more based on respect than love") and described his older brothers as "tough men" who personified strength. Communication between the male members of Leo's family was, as elsewhere, restricted to discussing practical matters and to "kidding around" which emphasized Leo's sense of difference.

> *It's hard to live up to your brothers. I felt that I didn't really belong. I don't know. I can't talk to them at all. I have said it to them. I don't know my brothers the way I should know them. Anytime we see each other we always start messing. No one is ever serious.*

In the aftermath of Leo's suicide attempt a brother revealed that he suffered from depression and Leo's response to this disclosure, and to his brother's attempt to engage authentically with him, was to redefine this sibling as "different" and the narrative contains elements of vulnerability and strength, as noted in other accounts of male communication (Schwab et al., 2016).

> *One of my brothers, he came in and he said "what's wrong with you" and he started crying and I started crying as well. He's kinder with me in a sense and I put it down to him not being a hard chaw. All my brothers are big and he's not big. That's what I think. And he started crying and I started crying and he said "just come on, we'll talk about it, it'll be alright" and I just told him "it's hard enough but you get through it".*

These stories illustrate the existence of hegemonic practices including the regulation of feeling in the participants' homes. These masculinity ideals were contested but complete rejection of the prevailing masculinity was difficult due to expectations

within the home and enforcement in the neighborhood. This could lead to feelings of helplessness as in Leo's case. He sought a very different masculine identity from his father and brothers but felt he lacked the educational and economic resources to pursue another way of life and was aware of the consequences of deviating from local gender norms as he had been victimized in school.

> *It's like being trapped. Did you ever have that feeling that like you felt you didn't really belong where you are? It's kind of like that. Sounds weird but maybe I shouldn't have been born or something.* Leo

The regulation and enforcement of behavior by peers

Expectations relating to male behavior and expression existed within the family but practices of hegemonic masculinity were rigidly enforced outside the home.

> *So you just get shunned if you're different. That's being a fag. When you're growing up there's a lot of pressure not to be gay. . . . if you're gay you get an awful time. Life should be wife and kids, that's life. . . . Gay and feminine is the same. They just think that what you're wearing or the way you stand or the way you sit or your hands move when you talk that you're gay so you get punished for that in society especially when you're teenagers and I certainly did. . . . That's the way men are.* George

These norms were generally not endorsed by the participants but they were conscious of exhibiting acceptable markers of masculinity and having a gay identity was hazardous, evidenced by accounts of victimization and the fact that being unable to disclose one's sexuality was directly implicated in at least two of the suicidal actions. Accessing alternative masculinity sites was difficult as the majority of the men felt they lacked the economic and educational resources to do so. In general they conformed, at least superficially, by managing performances and concealing vulnerability.

> *I've always grown up in a bit of a rough area, you know what I mean. My whole life has been surrounded by drugs. . . So you don't like to leave out, don't like to give any sign of weakness or. . . tell your closest friend that you might be this or you might be that, you know what I mean. People can turn and use it against you, you know that way. . . That's why I wouldn't say anything to anyone.* Liam

School was a key site for enforcing hegemonic masculinity and was a profoundly negative experience for many of the study participants. Almost all the men went to all-male, public (non-fee paying), schools in the locality and there were few opportunities for movement between schools. People were victimized for a multiplicity of reasons but any signifier of weakness was targeted.

> *It was down to someone who wears glasses. Someone with something that is different. If you're quiet that's it, you can't be quiet. You have to be some way outstanding or you don't survive. I was picked on a lot at school. I had an awful lot of torment in school over the years. I wasn't one of the strongest boys. But as I got older obviously I got bigger and bigger and was able to fight my own battles and I had friends and that was grand then. But before that I was tormented as a kid. Primary was hard. . . . I always had a good friend. I always had good friends wherever I was but the bullying aspect was always there and that used to get me. I think it was just generally picking on the weaker ones.*
>
> ***Did it affect you?***
>
> *It did yeah, that's why I'll never recover from it. The way I let it happen. It's probably up to me to face that but that's the way I let it happen. You don't feel as adequate as the others.* Matt

The consequences of bullying continued to haunt the victims long after they had left school. Victimization seemed to instill in the affected men a perception that they were weak and inept and ended the educational aspirations of people like Nicolas who had intended to go to university but were forced to leave school early '*because I was abused when I was in school*'. The misery caused by victimization was often compounded by family difficulties as these situations frequently made one susceptible to bullying and made it less likely that the victimization would be disclosed.

Father-son relationships

Father-son engagement added gender and emotional complexity to the hegemonic environment these men inhabited. Relationships with fathers were a consistent theme in the men's stories, from childhood reflections to adult experiences, including encounters with fathers following the suicide attempt. Father-son relationships were almost never close, more commonly antagonistic and at times mired in violence. Conflict related primarily to the father's inability to demonstrate love and care for his son (*seeking love and care from the father*) and or to the father's abusive behavior *(rejection by the father* and *violent fathers).*

Seeking love and care from the father

The love and affirmation of fathers was consistently sought by the men in this study but rarely demonstrated in an observable or consistent way and the hegemonic norms which

prevailed within the home contributed to this situation. Father-son relations operated within the framework of emotional restriction described above which prevented the communication of feeling needs and this was a barrier to bonding between fathers and sons. The fact that the father was the authoritative male figure within the household added complexity to this situation and a common criticism directed at fathers was their inability to engage in a caring way while at the same time exercising power within the home.

> *I don't get on with my father. I don't know. When I say I don't get on with him, I see him, I speak to him. I never talk to him. He never talked to us. He was just a normal sort of, go to work, come home, have dinner, watch a bit of telly, go to bed. I probably would have liked to have been closer to him when we were younger but it wasn't really an option. I certainly wouldn't call him warm. He was strict. I don't really remember an awful lot about him when I was younger. My father was a person who didn't show his feelings. He still doesn't even now. . . . It was just a normal childhood. . . . We had the strict side of it alright, very strict. Don't question it. If you did go against it you'd get a hiding. Not all the time, not to a serious extent. It probably seemed serious at the time. My dad used to slap us. Yeah, I was afraid of him, I suppose, in a way. If he said something you'd do it quicker than for my mam. . . . I suppose we were never asked for our opinion. Nothing was ever discussed. "That's what it is, take it or leave it" or you couldn't even leave it, "take it". I'd say that is more important to children, that you talk to them in a proper manner like I talk to you or you talk to me and treat them like an adult. If you treat them like they have intelligence they'll use it at least.* Larry

Larry's resentment of his father and his behavior resulted in serious, sometimes violent, confrontations between them and influenced Larry's life choices in significant ways. At a point when he had the opportunity to pursue the career he wanted he refused a place in university when his father encouraged him to take this up and offered to support him financially.

> *I had the chance but I didn't take it which didn't go down very well* (with his father). . . . *I was going to do* (subject named) *in* (university named) *and I had the points* (grades) *and all but at that stage I had worked about three or four months in* (mentions employment). *I came home on Tuesday night about two in the morning. It was very late anyway and my dad was there, still up, waiting up. Of course I got the letters* (from the university) *but didn't show anybody and he was there with the cheque on the table saying "you're going and that's it". So I said "no I'm not". So that was it, end of conversation, never discussed again. This was a person who hadn't taken an interest in eighteen years.*

In common with many of the men in this study, Larry left an unhappy home situation to form an intimate partnership in early adulthood and while he was highly critical of his father's lack of emotional engagement, he recounted a similar pattern of avoiding intimacy with his wife and children, became increasingly unhappy in his marriage and, like his father, began to drink heavily. In this way, intimate partnerships, which offered the potential for offloading painful feelings and attaining emotional security, were a risk factor for these men as the psychological liabilities they brought to the partnership often contributed to its demise and this frequently precipitated the suicide attempt. According to Larry his upbringing had not equipped him with an understanding of, nor a repertoire to deal with, his emotional needs and following two near-fatal suicide attempts (and the ending of his marriage), he decided to engage in counseling to address these issues.

Similar themes were evident in Kieran's story. He had experienced significant trauma in childhood and sought emotional comfort within an intimate partnership in early adulthood but when this ended he attempted suicide. Kieran disliked his father intensely and cited this as the reason for spending much of his early childhood in a relative's house where he was sexually abused. When the abuse become known he was taken into care and refused to confirm that the abuse had occurred as he wanted to protect the perpetrator who, according to Kieran, had provided the kind of love and care his own father had failed to give.

> *I loved him. I still do and it's very hard even now, it's very hard. I really cared about him. I knew what happened was wrong. He'd be there if I was playing a football match and come up and watch me and stuff like that. Just things. . . . He was a very hardworking man and that and far from my dad. He'd be more like he'd look after his family better and stuff like that.*

Kieran's attitude toward the perpetrator of the abuse contrasted with the anger he directed at his father who he portrayed as an inadequate husband and father whose deficiencies were responsible for the trauma he suffered in childhood. As he relates, the relationship was antagonistic and there was no possibility of him confiding in his father about the abuse.

> *I just never liked him. I never used to see that as home. . . . I remember one time when I was about fourteen and looking at him and saying "I'm going to get you eventually, you know that". I hate my father, hate him. I have no feelings at all for him. Literally nothing. I hate the man. I am not a fool, I am not a hypocrite. That's just the way I feel and that's the end of it. . . . I was in the hospital the other night after that*

(suicide attempt) *happening and I woke up and he was there and he started talking to me. I just ignored him. Even in the state I was in.*

Trauma experienced in childhood impacted on psychological wellbeing but was generally concealed by the participants as they were fearful of the implications of such disclosure. Although Kieran did well in school and had a supportive group of friends, these childhood events affected his self-esteem and were a source of ongoing distress. He coped by masking and sublimating uncomfortable feelings but the experience of the abuse and the complexity of his feelings for the perpetrator, as well as spending time in care, represented significant, unresolved, issues for Kieran and caused ongoing difficulties in his relationship. As he describes, these issues resurfaced following the breakup of his relationship.

I think I am very insecure. I put out a great confident attitude but I'm not really. Like everybody that knows me would say yeah I'm very confident and one of my best mates in the hospital the other night said to me you're the last person in the world I'd expect to do it. . . . (I) *Bottle things up.*

Did you tell anyone about your childhood, about the abuse?

I don't know, it's tough. I just wouldn't. I probably would be ashamed of it probably, yeah. I don't think I really have worked it out to be honest with you. I don't think I have.

Why do you think?

I still don't, not saying nothing was wrong but I didn't see harm in it.

Are you ok with that?

I shouldn't be okay with it. Maybe I am okay with it but I shouldn't be okay with that. I shouldn't be. I should know that's wrong. I should know like that is totally wrong and if anybody had done that to one of my brothers or sisters or my (gender of child mentioned) *I would go mad so why am I not going mad because it happened to me. I don't know, I'm just very. . . . I don't think I have worked it out. I don't think I ever have. I don't think I ever sat down and went through the total story. I have to get over this and I'm not getting over it. . . . I don't think it's coming from that specific issue. The fact that I spent a year in a children's home and I was going here, there and everywhere. . . . I wanted to protect him and I didn't want to go home to my mums. I couldn't handle that again. . . . There was nobody protecting me. It was even there with the whole thing of the break up. . . . I think the whole thing now with this break-up is that I, remember I told you how I used to go home some weekends and I'd have to go back home, back to the children's home after the weekend and how hard that was for me. Now I'm walking away from her/him* (his child). *I can't see her/him. I don't want to see her/him. I've tried to see her/him over the past three months but I've only seen the child three times. I can't do it. I had her/her out with me yesterday, I had her/him out for a few hours walking around. Crying, just walking around, playing with her/him and then crying. I can't go back or I'll go to bits. I can't do it. Too many bad memories. It's too hard.*

Rejection by the father

A number of father-son relationships involved explicit rejection by the father and Dermot's and Fergus's stories are similar in that both concerned their paternity and the father's belief that he was not the man's biological father. Fergus grew up in a home where the communication was gendered, controlled and abusive and where he was a target for his father's anger and rejecting behavior from a young age. He felt powerless to resolve the situation and felt guilty that he was somehow responsible for the rejection. He described a critical event in his life, the occasion when his father told him that he was not his biological father, information which had previously been referred to during alcohol-fuelled outbursts but was now imparted directly to Fergus as he was leaving home to start university.

Oh I'll never forget that. There's always been a thing. Well not so much lately but when I was younger there was always a thing that my father wasn't my father. Not from my side but from his side.

Would he say that to you?

Not directly to me but in an argument or whatever with me mam and I'd hear it. There's a long trail there believe me.

That goes back to your childhood?

More or less yeah. I suppose when I first heard it and I kind of started thinking to myself, I would have been around twelve, thirteen, fourteen years of age. . . . I always kind of noticed it. Even when I was very young I said the one thing I do before I die is move out of this house before I'm eighteen. There'd be nights when he'd be drunk and I'd hear him slagging me off and saying really really hurtful things. He wouldn't be a violent man toward us. Now he's been violent toward my mam in the past but I shouldn't even say it but it's been drink orientated. There's never been any violence when he was sober. Just a man that's very kind of set in his ways and I was the oldest and I should have been doing this and I should have been doing that. That's half the reason why I didn't want to tell them anything. It's just being the oldest and I didn't want them to be ashamed of me. I was never as close to them as anybody else in the family and we're only a small family, there's only (number mentioned) of us. I was never as close to them as any of the rest of them were. Always about me and never about anybody else, always about me. It's like he had some sort of a vengeance for me. I don't even know to this

> *day whether he truly believes that I'm his son. I loved him but couldn't understand what I needed to do to make him kind of love me. Like I know now that he loves me but all I had to go through to kind of find it out.*

These narratives relate to paternal rejection and the hurt which resulted from this but also demonstrate the son's desire for the father's love and his attempts to salvage what he could from a problematic relationship. Fergus and Dermot hated the abusive behavior directed at them and dealt with the situation by constructing two identities for the father—the good father and the difficult father. This was a common response when the father was abusive as restrictions on expression and the father's status within the home ensured these conflicts were never openly discussed. Dermot felt unable to address the issue of his paternity with his father "as *it might hurt his feelings or whatever*" and Fergus's account of the interaction with his father following his suicide attempt suggests emotional constriction extending over generations, of uncomfortable feelings redirected into anger and violence and the use of alcohol to suppress emotional pain.

> ***How did your parents respond when they found out?***
> *I don't really know but I've only seen my dad for a few hours this morning. He didn't really say much. Me ma came in last night and she was kind of tearful.* (She said) *Me da kind of couldn't understand why we didn't talk to one other.*
> ***When your father came in what did you talk about?***
> *He didn't mention it. He's not good at that kind of thing.*

These stories demonstrate the negative effects on the man's wellbeing of a father's abusive, rejecting, behavior. The participants experienced sadness, shame and self-blame, felt isolated within their families and unable to confide in them. Dermot described his position in the family as *"like the odd one out, well not odd one but kind of left out of things"* and Fergus referred to himself as "*the black sheep*". Both men hoped that forming intimate partnerships would provide a safe emotional space and help ameliorate these feelings but this did not happen and when the partnerships ended they attempted suicide.

Violent fathers

The most hostile father-son conflicts occurred in families where there was physical violence and this was a relatively common occurrence as almost one third of the men were raised in homes where violence was a consistent feature. The mother was usually the victim but some of the men had been subjected to ongoing physical abuse as children. Violence in the home was generally linked to paternal alcoholism and in these instances the participants described childhoods infused with fear and volatility.

> *My father was an alcoholic most of my childhood. He'd go from being nice and come home and be someone totally different and then wake up that evening shouting and hitting and kicking. He hit us all. Six nights a week he would come home and be a different person. Just afraid to do anything and I'd just go up to my room. If my sisters were downstairs he'd probably slap them or whatever. The oldest brother left home. I don't know if he ran away or just left home but he left home one night. He used to share the same room and I woke up and the wardrobe was empty and he'd moved.* Ronan

Frank, who was regularly beaten by his father, along with his mother, described a fear-filled childhood and relief when his father left the family home ("*I was just delighted that he left*"). These childhood events affected these men's sense of security and control and made them fearful of pursuing the lives they wanted. Frank was unable to leave an unhappy relationship, which he cited as the precipitant for the suicide attempt, and, as he was reluctant to address issues about his sexuality, refused to engage in therapy. In David's family his father's alcoholism had resulted in violence and a precarious economic situation over many years. As the eldest child David felt a responsibility to protect his mother from his father's violence and his relationship with his father growing up was underpinned by anger but also sadness due to his father's rejecting behavior. Yet, like other participants, he re-engaged with the reformed father although this occurred within the confines of hegemonic constraints on expression.

> *There's a bit of friction between the two of us. He used to be an alcoholic and he gave it all up ten years ago. He was pretty difficult. He drank a lot. . . . Nothing I really like to remember. He was violent to my mother. He's a different person now. He was violent to me a couple of times. I was always in trouble. Every time he came in drunk I was in trouble. She* (mother) *had a hard enough life too. There was never any money there. I remember hating him when I was young. I remember when I was in primary school. I used to come home from school and she might only get dinner once or twice a week because there wouldn't be enough food. She would feed the boys but she wouldn't have eaten for the day. . . . My father was getting big money at the time from work and it was all going on drink. At the time I remember when he had the problem, when I was going to school I had nothing but cheap clothes. I was very sensitive about that and I'd blame it on him. I was never proud of my father. I'd be proud of him now the way he was an alcoholic and the way he turned himself around. I'd be proud of him now but back then no, I absolutely hated him. . . . . I hated him and I think he knew that as well.*
> ***How is your relationship with him since he gave up alcohol?***
> *Ok. He's a different person now.*
> ***Is he the kind of person you could talk to?***

No. I don't think so, no. I couldn't talk to him anyway. I feel awkward with him. I talk to my mother alright. . . . Probably because I remember when he used to drink and the fighting. . . . When I was in the hospital I was told my father was down in the dumps because I hadn't told him. He said that he thought I could talk to him about everything.

Have you and your brother ever talked about when you were young.

No. I don't even think about when I was young to be honest. . . . There was a row in the house and someone confronted him about the drink. It nearly killed him. He went out of the room. . . . Yeah, he just had to go away.

It's not something you could discuss with him.

I'd never bring that up. It's in the past like you know. He was a different person back then. He wasn't himself.

Adam had also re-engaged with his father although he had suffered sustained physical abuse from him from an early age, a situation which became normalized for him.

My father was an alcoholic and he had violent tendencies toward me. He physically abused me as a kid. It was always just me.

How often would that happen?

Once every few days

And how did that make you feel?

Afraid. . . . I suppose resentful I guess now that I have gotten a bit older. I still talk to him..... It wasn't entirely his fault, he's manic depressive and he's an alcoholic. I don't think it's entirely his fault.

But at the time?

I was terrified.

You feel differently about him now?

Yeah, I feel sorry for him.

When you were growing up, did you have someone to talk to about your problems?

No.

Did you ever tell anyone?

No.

Did you talk to your mum?

No.

Did you have any close friends at that time?

A few, yeah, but I didn't talk to them about it because I thought it was normal, I thought it was like that in every house. I didn't think it was abnormal. When you grow up with things you think they're normal, it's only when you start watching television it seems that like (they are not).

Men who experienced an abusive environment as children recounted the long-term effects of this on their self-esteem and many, particularly those who were victimized in school, described a kind of layering or build-up of distress over time. The adversity experienced by these men would be challenging for any individuals but their situation was compounded by the lack of an outlet to speak about these events as they felt unable to do so due to gendered restrictions on expression. Confiding in fathers was not an option for these men and other family members and male friends were regarded as equally inaccessible (Cleary, 2019). In contrast to traditional accounts of male and female psychological processes, painful feelings were internalized and only rarely directed outwardly *via* violent behavior. A background narrative in these stories was the generational transmission of hegemonic masculinity cultures and their effects. Participants' accounts of their fathers' behavior suggested that they lacked the ability to engage meaningfully with their sons and did not have a language to express nurturing feelings. The evident unhappiness of many fathers, implied by the men's accounts of their fathers' behavior and alcoholism, appeared to represent the transmission of this unhappiness as well as deficient models of masculinity into the next generation.

His father abused him for years. . . . . I'd say my father was asked to go for help. I'd say he was. He had to be told he needed help at some stage in his life and I think that he did probably at one stage maybe try and didn't like it or something, and that was it. Sean

Discussion

Linkages between practices of hegemonic masculinity, particularly emotional constraint, and male suicide have been identified in the research literature (Cleary, 2012, 2019) and the aim of this study was to explore the implications of exposure to family and neighborhood cultures of feeling restriction and the contribution of fathers and father-son relations to these environments. The study, based on a sample of men who made a clinically serious suicide attempt in adulthood, illustrated how the masculinity scripts available to these men, who were predominantly from low socioeconomic backgrounds, defined manhood in narrow, conventional, terms, emphasizing strength and discouraging expressions of vulnerability. The theme *learning about masculinity* revealed how the culture of masculinity and emotional expression these men were exposed to growing up shaped their ideas about gender and what were acceptable practices for males. This masculinity framework was contested and the men's accounts suggest that adherence to these gender norms was more accurately about public display while in private they held more flexible views. They felt pressure to conform due to expectations within the family and, as revealed by the theme *the regulation and enforcement of behavior by* peers, they feared the consequences of diverging from hegemonic ideals in the neighborhood. Bullying was used extensively in schools to enforce conformity to these practices and they were largely confined to these areas growing up due to socioeconomic

factors. In this way hegemonic principles became the baseline and working model for the men's masculinity performances and socioeconomic factors constricted their ability to explore alternative possibilities, as described elsewhere (Redley, 2003; Turner et al., 2006).

Fathers were significant figures in these men's lives and were instrumental in providing and scrutinizing early and ongoing markers of masculinity. The emotional culture within the home was gendered, in line with hegemonic ideals, and there were distinct male and female expressive and interaction styles. This gendered emotional culture shaped male behavior and relations within the home, including father-son interaction, and inhibited the communication of feeling needs and the development of nurturing bonds between fathers and sons. The third theme (*relationships with fathers*) demonstrated the influence of the father on the man's practice of masculinity and the implications of negative father-son relationships for both gender and wellbeing. The theme *seeking love and care from the father* indicated that the participants sought an intimate connection with their fathers but relations with fathers, whether they lived within or outside the home, were lacking in emotional closeness, almost never harmonious and more commonly antagonistic. Fathers were generally perceived as emotionally distant, as unable or unwilling to express love and care and some fathers were rejecting and abusive toward their sons. These findings support other research work which indicates that hegemonic masculinity principles are a barrier to close, nurturing, father-son relationships (DeFranc and Mahalik, 2002). While a father is not essential for a boy's wellbeing (Pleck, 2010) nurturing father-son relationships are beneficial for the young male's emotional development and mental health (Lamb, 2010; Adamsons and Johnson, 2013). In this study, fathers adhered to hegemonic principles and there were almost no examples of fathers who openly and consistently nurtured their sons. The intergenerational transmission of deficient models of emotional communication and father-son relationships, identified elsewhere (Brown et al., 2018; Jessee and Adamsons, 2018), was also apparent in this study.

As in other studies of male suicidal behavior, many of these men were exposed to ill-treatment and trauma in childhood and this issue is explored in the themes *rejection by the father* and *violent fathers*. Paternal violence and alcoholism was relatively common and this caused suffering and anger and limited the participants' emotional, social and economic lives as they grew. Yet, these men did not replicate the father's violence and sought to salvage something from these relationships and connect with their fathers. Growing up in a problematic family resulted in emotional and physical suffering and affected their psychological security from a young age and this is supported by similar findings (Molnar et al., 2001; Seguin et al., 2011; Hughes et al., 2017; Giupponi et al., 2018). The type of violence they experienced impacts on one's sense of security and control and is associated with suicidal behavior (Dube et al., 2001; Enns et al., 2006). Difficulties encountered at home frequently led to other problems such as victimization in school and the result was a build-up of distress over time which has implications for mental health (Oliffe et al., 2021). Adverse childhood experiences require an appropriate response to avoid negative outcomes (Seguin et al., 2011; Hughes et al., 2017; Giupponi et al., 2018) but constraints on emotional expression and shame prevented the participants from speaking about their suffering and this exacerbated their situation and made it more likely that the psychological burden was carried into adulthood. As in Ridge et al.'s (2020) study the men lacked self-esteem, felt they had under-achieved in academic and career terms and recounted ongoing distress and situations which rekindled memories and unsettled their security. They coped by denial and rationalization, by self-medicating, and by seeking emotional solace within intimate partnerships. These patterns have been reported elsewhere in the literature (Afifi et al., 2009; Hughes et al., 2017) but self-medication is likely to aggravate these situations (Cleary, 2019) and, as Oliffe et al. (2022) have also demonstrated, the complexities these men brought to partnerships tended to destabilize them and they were especially vulnerable when relationships ended. These findings, which add detail to the processes and impact of emotional constraint, may help to explain the higher risk of suicide for males, compared to females, following childhood trauma (Dube et al., 2001; Wagner et al., 2003; Afifi et al., 2009; Weich et al., 2009) and more generally, provide insights in terms of higher male, compared to female, rates of suicide.

Conclusion

This study, based on a sample of men who made a clinically serious suicide attempt in adulthood, revealed how exposure to a hegemonic form of masculinity from an early age influenced the men's gender practices and their wellbeing. The results illustrate how hegemonic type masculinity cultures restrict males in learning about and negotiating the emotional issues of their lives and the importance of family, fathers, and neighborhood in the development and continuance of these gender practices. The participants felt pressure to conform to the prevailing masculinity due to expectations within the family and the enforcement of these practices in the neighborhood and socioeconomic factors constricted their ability to explore alternative gender possibilities. In these circumstances, this form of masculinity became a working model for the men's masculinity performances but this does not imply the homogeneity of male behavior and experiences even within particular communities. Men do not have identical lives nor experiences and life trajectories are variable whatever the personal, cultural, or structural background. However, these

results indicate that a specific combination of experiences and situations create a higher probability of prolonging distress and layering problems over time. The masculinity culture they inhabited required them to suppress particular emotions, disguise vulnerabilities and conceal distress and this entailed a psychological burden over time especially for those men who had encountered trauma growing up. The experiences of these men are important in understanding the motives of those who attempt suicide as they provide detail on how emotional constraint can impact on young males, particularly those with restricted social and economic options. They were capable of discussing their emotional lives in considerable detail as demonstrated at interview and this, along with the wide array of feelings conveyed, implies a facility to address these issues as well as refuting binary ideas about emotions (Shields, 2007; Patulny et al., 2017). The results suggest a need to re-examine gender barriers to disclosure and treatment (Cleary, 2017) and to replace binary and singular ideas about men's emotions with more realistic concepts in suicide prevention programs. The findings, which indicate the importance of fathers to male lives and wellbeing imply a requirement to incorporate the benefits of emotionally engaged and affirming fathering into Public Health campaigns and discussions. More specifically, health providers might provide upskilling in communication for parents, especially fathers, to assist them in the aftermath of a son's suicide attempt.

Data availability statement

The qualitative data presented in this article are not available due to confidentiality requirements. Requests for further information should be directed to anne.cleary@ucd.ie.

Ethics statement

The studies involving human participants were reviewed and approved by the ethics committees of the participating hospitals. The patients/participants provided their written informed consent to participate in this study.

Author contributions

AC conceptualized and developed the study, conducted all interviews, analyzed the data, and wrote the paper.

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Conflict of interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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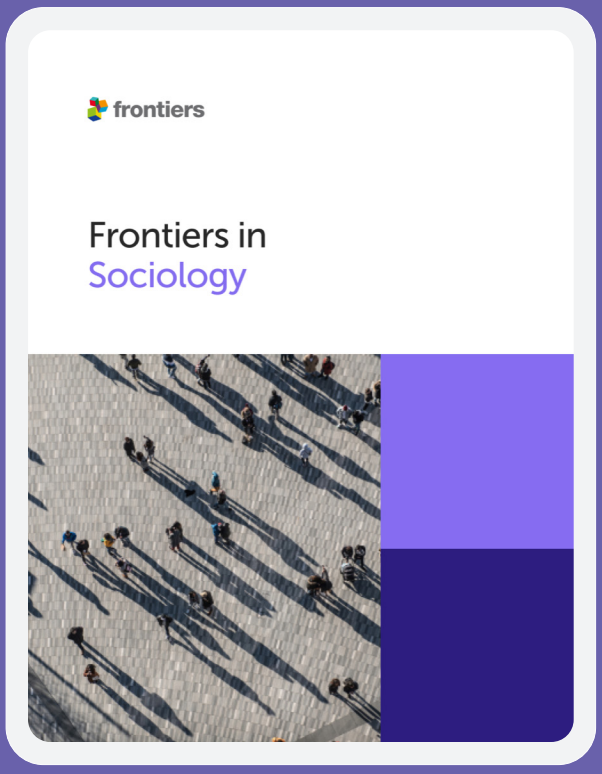

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