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Diverse and Dynamic Interactions: A Model of Suicidal Men's Help Seeking as It Relates to Health Services

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Abstract

There is a striking gender difference in suicide rates worldwide, with men accounting for approximately 80% of all suicide deaths. In contradictory public discussions, suicidal men are presented sometimes as victims of "poor" health services and sometimes as irremediable, "poor" help seekers. A more substantive theory of suicidal men's help seeking, which moves beyond homogenizing accounts to examine the complex interplay between help seeking and health services, is now required. Eighteen life history interviews were undertaken with men who had engaged in nonfatal suicide. Interviews were analyzed within a theoretical framework of gender relations. The findings challenge static and uniform notions of suicidal men's help seeking. While a few men actively avoided health services, others actively sought help, and in many cases help-seeking practices were triggered by unsolicited encounters with health services. Responsibility for help-seeking behavior did not rest solely with suicidal men. Men's help-seeking practices could either be facilitated or blocked by the character of the professional support that was available. Men in this study overwhelmingly rejected services that framed emotional distress and suicidal behavior as mental illness.

Keywords

help seeking, health services, suicide, men, masculinity

The gender difference in suicide rates is a familiar point in the literature. The World Health Organization (2011) reports that men account for 80% of the approximately one million suicide deaths worldwide each year, with men's suicide deaths exceeding women's in every country except China. Men's high rates of suicide are frequently linked to health service issues. In contradictory public discussions, suicidal men are presented sometimes as victims of "poor" health services and sometimes as irremediable, "poor" help seekers (e.g., Macdonald, 2011; Möller-Leimkühler, 2003). Both accounts offer a distinctly homogenous view of men and health services, and fail to consider—in a more meaningful sense—the variable nature of men's help-seeking practices in relation to the diverse health services that men encounter (Wenger, 2011).

A more substantive theory of suicidal men's help seeking is now required, particularly one which moves beyond uniform and disjointed accounts of men and health services. This article contributes toward this aim. It outlines the conceptual problems in the current literature on suicidal men's help seeking and health services. Then, drawing on a life history study of suicidal men's help-seeking practices in Australia, a theoretical model of suicidal men's help seeking is proposed.

In 1897, Durkheim (1951) presented the first sociological analysis of suicide in his famous work, *Le Suicide*, which used sex-difference statistics from across Europe. Since this time, much of the social research on suicide has relied on sophisticated sex-difference studies. In regard to help seeking, the overwhelming finding from sex-difference research is that suicidal males are far less likely than suicidal females to seek support (e.g., Booth & Owens, 2000; De Leo, Cerin, Spathonis, & Burgis, 2005). The relationship between sex and help seeking in suicidal individuals is, however, more complex than it first appears, with estimates varying considerably between studies. For example, Booth and Owens (2000) reviewed multiple sex-difference studies of suicidal individual's help seeking and noted a marked difference in findings. While some studies reported decidedly high rates of help seeking in males (62%) compared with females (24%), others reported relatively small margins of difference between males (76%) and females (56%;

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Booth & Owens, 2000). It is also the case that a significant portion of the literature reports no difference between male and female help-seeking rates in the context of suicide and other health issues. In other words, they report "sex similarity" in the help-seeking behaviors of men and women (e.g., Galdas, Cheater, & Marshall, 2005). Indeed, Galdas et al. (2005) reported that "poor" help seeking was more significantly related to (actually) being poor than to being male, suggesting that socioeconomic factors may be a more important variable than sex in regard to help seeking.

Very little sociological literature on suicide draws on gender theory. Durkheim (1951) himself largely overlooked the issue of gender difference in suicide rates. Feminist critiques of Durkheim's (1951) work indicate that he read the higher rates of suicide deaths among men as evidence of men's superior intellect and higher social integration (Jaworski, 1999, 2007). Möller-Leimkühler (2002, 2003) is one of the few suicidologists to draw on gender theory to examine help seeking. By drawing on sex role theory, she was able to provide an influential role theory of suicidal men's help seeking. Möller-Leimkühler (2002) argued that help seeking "offends" male role expectations, as men must remain strong and emotionally self-sufficient. Similarly, Houle, Mishara, and Chagnon (2008) drew on the notion of gender roles to argue that adherence to traditional roles influenced help seeking in suicidal men. Feminist, gay, and profeminist scholars have provided a robust critique of sex role theory, arguing that it presents men and women as distinct, groups with uniform practice, and overlooks the impact of power relations between men and women, as well as among men (Carrigan, Connell, & Lee, 1985). Indeed, Möller-Leimkühler's theory assumes that *all* men have poor help-seeking practices, and overlooks evident patterns of difference among men (Galdas et al., 2005; Wenger, 2011). Moreover, Wenger (2011) argues that sex role theory tends to bolster stereotypes about men's help seeking, which thwart a more sophisticated understanding of men's efforts to seek support.

Some researchers have drawn on more sophisticated theories of gender. Cleary (2005) and others (e.g., Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012) have taken a gender relations approach to provide important new insights into the relationship between masculinity, help seeking, and men's suicide. Briefly, gender relations was first articulated by Connell in 1987 in *Gender and Power*. Connell (1987, 2002, 2005) contends that gender is not fixed by social roles rather it is a way that reproductive bodily differences are played out in social practice. Multiple patterns of *masculinities* result from the dynamic interplay between agency, gender, and other social structures such as class, religion, ethnicity, and sexuality, which abrade and constitute each other into a hierarchy of masculinities (Connell & Messerschmidt, 2005). Connell and Messerschmidt (2005) argue that one pattern of masculinity, "hegemonic masculinity," is socially privileged and structures and legitimizes a hierarchy of relations among men and masculinities, as well as between men and women, and between masculinities and femininities (Messerschmidt, 2000). Using gender relations theory, Cleary (2005) reported that hegemonic masculine ideals constrain emotional expression among suicidal men, which prevents help seeking. However, Cleary (2005) did not indicate any variations in men's help-seeking behavior, and her study leaves us with questions about the possible heterogeneity of men's help-seeking practice. In particular, how men might actively engage with or resist dominant notions about masculinity, and how this affects their efforts to seek support. Although Johnson et al. (2012) specifically focused on depressed men—rather than suicidal men—their study is one of the few to acknowledge the diversity of men's help-seeking practice. They indicated that some men reject dominant masculine discourses that block help seeking and adopt alternative caring discourses that enable help seeking (Johnson et al., 2012).

While the work of Cleary (2005) and Johnson et al. (2012) represented a shift in the sociological literature on suicidal men's help seeking, implicit in this literature is the notion that if (only) men's help-seeking practices could be improved, then men's engagement with health services will be somewhat automatic. Still it is not necessarily the case that health services will automatically meet the needs of suicidal men who seek professional support.

There is a small body of literature examining the "problem" of health services for suicidal men. For example, Macdonald (2011) argues that health services are not "male friendly" as they are oriented toward the needs of women and fail to understand the "male" perspective. However, it is not clear what would constitute a male-friendly health service, with suggestions ranging from seemingly trivial measures, such as having more men's magazines in doctor's clinics, to ostensibly more consequential measures, such as longer opening hours for doctor's clinics (Holden, Allan, & McLachlan, 2010). Courtenay's (2000) analysis of health services has been particularly influential in the field of masculinities and men's health. He argued that health services construct men's bodies as resilient and normal, which in turn reduces the possibility of health professionals recognizing health issues in male patients (Courtenay, 2000). Indeed, Strike, Rhodes, Bergmans, and Links' (2006) Canadian study indicated that men often had irregular and difficult contact with health services. However, Courtenay (2000) tends to assume that *all* health providers offer a uniformly poor service to men. Yet little is

known about the diversity of health services or the interplay between men's help-seeking practices and health service response (River, 2014).

An emerging body of research draws on gender relations to provide a more nuanced understanding of men's help seeking as it relates to health services. Wenger's (2011, 2013) study, which examined men's efforts to seek support in the context of a cancer diagnosis, is notable in this regard. Wenger (2011) was able to move her analysis away from uniform accounts of men and services, to report that men with cancer can, and do, actively seek help, and their help seeking is not necessarily a "one off" event (p. 491). Rather men's shifting health needs, and the variety of cancer services that they encounter, make help seeking an ongoing and relational process (Wenger, 2011).

Although the work of Wenger (2011) illuminates the diverse and relational nature of help seeking in men, only tentative connections can be made to the situation of suicidal men. There is a distinct stigma associated with suicidal behavior (Taylor, Hawton, Fortune, & Kapur, 2009) and services to suicidal men continue to be shaped by the psychiatric model of care (Hunter, Chantler, Kapur, & Cooper, 2013). Men may, therefore, be more reluctant to seek support due to fear of encountering discrimination or being labelled as mentally ill.

This article reports on a qualitative study, conducted between 2009 and 2014, that used a gender relations analysis to theorize a model of help seeking in suicidal men. The study specifically sought to understand the variability of suicidal men's help-seeking practices and how this relates to, and interacts with, the kinds of health services that men encounter.

Method

Connell (1995) established life histories as a method for exploring individual life stories to theorize gender relations. It is a recognized approach within the masculinities field. Notable studies include Messerschmidt's (2000) *Nine Lives*, which illuminates issues related to violent crime in adolescent males; Messner's (1992) *Power at Play*, which provides a provocative appraisal of male athletes in professional sport; and Dowsett's (1996) *Practicing Desire*, which investigated sexual practice within the gay community of two cities in Australia during the era of Acquired Immunity Deficiency Syndrome (AIDS). As Plummer (2001) notes, life history method allows researchers to build social theory from personal narratives. When used in conjunction with gender relations theory, it can capture the plurality and complexity of men's gendered social practice (Plummer, 2001). This method was, therefore, particularly useful for a project that aimed to build a substantive theory of help seeking in suicidal men.

Limitations

Life history is a qualitative method that seeks to build theory rather than test hypotheses. Indeed, the value of qualitative methods is in allowing patterns to emerge that are not predicted in advance (Yardley, 2015). The findings from this study can, therefore, offer important insights into the dynamic men's patterns of help seeking as they relate to health services, but they cannot claim to be generalizable. To test the generalizability of the patterns would require research methods that allow results to be inferred to the broader population.

Denzin (1995) also argues that life history accounts must be understood as reconstructed narratives. It is the researcher's theoretical questions and interpretations, and not the participant, who organizes and structures the life history account. Still theoretically reconstructed life histories have particular value in providing a critical analysis of social practice. As Gorelick (1996) argues, to avoid reiterating oppressive ideologies, we need to do more than just give voice to participant stories.

Participants

Ethics approval was obtained to recruit men who had engaged in nonfatal suicide. Identifying nonfatal suicide is no easy task. There is no consensus with the literature regarding suicide terms, with multiple terms and competing definitions from various fields (Leenaars et al., 1997). Confusion around terminology also arises from ongoing debates about what constitutes suicidal behavior (Canetto, 1993, 1995). This article does not intend to solve these terminology issues, instead it adopts terms already put forward by Canetto and Sakinofsky (1998), who suggest the term "fatal suicide" to denote a suicidal behavior that ends in death, and "nonfatal suicide" to indicate a suicidal behavior that is not life ending.

This study aimed to recruit men who had different levels of contact with health services. Researchers are often reluctant to recruit men from within the community as it is assumed that men will not come forward to discuss nonfatal suicide (Elnour & Harrison, 2008). However, to gain a better understanding of men's patterns of help seeking, it is essential to understand the practices of men who have little or no contact with health services. This study, therefore, explicitly sought to recruit Australian men currently accessing health services as well as men with no current contact with health services. Health services were broadly defined as services provided by health care professionals and community organizations.

Eighteen men were recruited in total: 2 (11%) were recruited through health services, 3 (17%) were recruited via community organizations, and 13 (72%) were recruited through advertisements in local newspapers.

Participants came from various urban areas and were aged between 23 and 66 years. They had a range of occupations including business or marketing (N = 4, 22%), manual labor (N = 3, 17%), real estate (N = 2, 11%), acting/entertainment (N = 2, 11%), health care (N = 2, 11%), hospitality (N = 2, 11%), law (N = 1, 6%), security work (N = 1, 6%), and clerical work (N = 1, 6%). Seven men (39%) were in long-term relationships, two men (11%) were married, four men (22%) were divorced, one man (6%) was widowed, and four men (22%) were single. Of the participants, four men (22%) identified as gay and one man (6%) identified as bisexual.

Participants' suicide practice was diverse. Nine men (N = 9, 50%) had tried to kill themselves on one occasion, eight men on two (44%) occasions, and one man (6%) on six occasions. This constituted 31 nonfatal suicide engagements in total. Participants had used various suicide methods. Five men (28%) hanged themselves, 2 men (11%) used a car to injure themselves, 1 man (6%) used a car to poison himself, 6 men (33%) stabbed or cut themselves, 1 man (6%) used a gun, 2 men (11%) went to a place where they contemplated jumping, 11 men (61%) overdosed on medications, and 1 man (6%) swam out into heavy surf to drown himself.

Men described various levels of contact with health services. Participants reported contact with psychologists, psychiatrists, physicians (hospital and primary care), nurses, social workers, and community organizations.

Data Collection and Analysis

Life history interviews were undertaken with participants. In each interview, men were asked to tell their story from whatever time point they wished and to highlight events that were important to them. The interviewer asked questions to clarify events and to cover topic areas that were identified prior to the interview. Topic areas included family relationships, education and school experience, work history, life events leading up to suicide, help-seeking behavior, and contact with health services.

Each individual life history was transcribed verbatim and analyzed by a team of researchers with considerable expertise in life history method and gender relations theory. At least two researchers reviewed and analyzed each interview transcript using the systematic approach outlined by Connell (1987, 2005). Each transcript was examined in relation to the four spheres of gender that have emerged from gender theory: power, production, symbolic, and cathexis (Connell, 2005). Power relations refers to the hierarchical ordering of gender in different contexts; production relations describes the gender division of paid and unpaid labor; cathexis refers to the complexities of emotional ties and sexual attraction; and symbolic relations draws attention to how gender is symbolized in society through mediums such as language, dress, gestures, and the media. Case studies were created for each participant and then collectively analyzed by the research team. Salient and recurring themes were noted. This included participant's patterns of help seeking and their responses to contemporary health services. The synthesized findings of the 18-participant group are presented. To protect the anonymity of participants pseudonyms are used and only excerpts from individual case analysis are presented.

Results

Diverse and Dynamic Patterns of Help Seeking Among Suicidal Men

The theorized life histories indicate that there was no set pattern of help seeking among men who engage in suicidal acts. Rather three distinct patterns of help seeking were identified. While a few men (N = 3, 17%) actively avoided health services—seeing it as "not too manly"—other men (N = 6, 33%), struggling with escalating distress, felt they had "nothing to lose" and actively sought help. For the majority of men (N = 9, 50%), help-seeking practices were triggered through unsolicited encounters with health professionals. For health professionals, these encounters provided a "window of opportunity" to engage men in health services.

The data identified, however, that responsibility for help-seeking behavior did not rest solely with suicidal men. Men's help-seeking practices could either be facilitated or blocked by the character of the professional support that was available. Men in this study overwhelmingly rejected services that framed emotional distress and suicidal behavior as mental illness. Even those men who actively avoided health services stated that they did so to avoid encounters with health professionals who operated within a mental illness framework. In contrast, a "person-centered" approach to care, which focused on the concerns of the men, maintained or promoted help-seeking practices. Although there was no evidence that the study men avoided so-called "feminized" health services, the lack of consideration for gender power dynamics within health services meant that some suicidal men's support needs were unmet.

"Nothing to Lose": Actively Seeking Help. Six men (33%) actively sought professional help when they had reached their lowest point. This often followed a protracted period of feeling distressed and suicidal. This kind of narrative will be introduced through the case of Jack, who engaged in nonfatal suicide on two occasions due to ongoing difficulties in securing satisfying work.

Prior to his first nonfatal suicide, Jack's pattern of help seeking followed the hegemonic masculine form proposed

by Cleary (2005). He avoided health services and believed that emotional self-sufficiency was an appropriate masculine response to trying circumstances. Eventually, trapped in insecure and casual employment, Jack was unable to contain his escalating distress. As Cleary (2005) suggests, he chose "death rather than disclosure." Rather than seeking help he tried to drown himself in heavy surf.

With the assistance of lifeguards, Jack survived his self-drowning. At this point, contrary to the predicted pattern for suicidal men, Jack altered his help-seeking practice. He believed that the strategy of emotional self-containment that he had adopted had essentially failed, and he had "nothing to lose" by contacting health services. In the first instance, he contacted a primary care physician and was referred to a psychologist. Jack's main hope was that the psychologist could help him establish a more satisfying career. This pattern of seeking help—as a means of establishing or reestablishing a satisfying working life—was noted in other men's cases.

This moment marked a critical juncture in Jack's account. At this point, the character of health services that Jack encountered, rather than his own help-seeking behavior, became the sticking point. Jack described his first visit to the psychologist,

> She [the psychologist] just said "depression." She just wanted to take me in the psych way, but she wasn't skilled enough to know where I needed to go really. So I thought I was wasting my time. She couldn't help me. . . . I mean depression is the sniffles. If you have a cold of course you are gonna get depression, but where that begins and ends is not depression. And that really pisses me off, because there are a lot of people out there really struggling and just being classed as depressive.

The ongoing focus on mental illness within health services has been widely criticized by service users for failing to meet the needs of suicidal men (e.g., Hunter et al., 2013). Jack's account provides support for these critiques, illustrating how the failure of services to adequately meet the needs of suicidal men can have serious consequences. The "psych" explanation was at odds with Jack's own perception of the issue and he did not return for treatment. He described feeling "helpless" and soon after reengaged in nonfatal suicide—this time by jumping from a moving vehicle.

Once again Jack survived, although he sustained considerable injuries. Despite his initial set back, Jack became convinced that the "right person" could help him overcome his suicidal feelings. His efforts to find that "right" person led him to another psychologist, Sarah. Rather than framing suicide as a symptom of mental illness, Sarah expressed an interest in issues pertinent to Jack. Jack described the impact of her approach, "I felt better instantly because, for no other reason than, I had someone I could talk to, share feelings." With Sarah's support, Jack was able to explore his career difficulties and, as he put it, his career "dreams." He eventually enrolled in design and technology course and found work in the film industry, which, for Jack, led to a pronounced improvement in his mental well-being.

From this point, the term "person-centered" care will be used to describe the approach taken by health professionals such as Sarah, where a collaborative approach that privileges the patient's narrative over a clinician focus is adopted. This is distinguished from a "clinician-centered" care, where the health professional sees suicidal distress through a psychiatric lens.

Jack was not alone in his experience of health services. The majority of participants' narratives reported that a person-centered approach to care was viewed as more effective and relevant for managing distress and suicidal feelings. It is also worth noting that Jack, and other participants, sought help on more than one occasion. As Wenger's (2011, p. 491) suggests, help seeking is not necessarily a "one off" event, but an ongoing process.

A Window of Opportunity: Unsolicited Encounters With Health Services. Nine participants (50%) had unsolicited contact with health services either prior to, or following, nonfatal suicide. In other words, they did not actively seek professional help, but came across it anyway. At this point, future help seeking could be either activated or discouraged depending on the character of health services that men encountered.

For example, David engaged in nonfatal suicide on multiple occasions. He was an openly gay man who became suicidal when his social networks were devastated by the advent of AIDS. He came into contact with hospital nursing and psychiatric services while receiving treatment for nonfatal suicide injuries due to self-poisoning. The health professionals that David encountered insisted on a clinician-centered approach. David found the psychiatric framing of his personal distress disturbing,

> You tell a nurse or a psychiatrist that you want to kill yourself, and they label it. I get very upset about it because you can turn around and say to somebody that you want to kill yourself and immediately it's thought you must have either a mental health problem, or you must be nuts.

Rejection of clinician-centered services was common among men who had unsolicited encounters with services. Most men who had contact with this kind of service were dissuaded from seeking further support. In some cases, the consequence of failing to meet men's needs had serious effects. David, for example, actively resisted diagnosis and treatment and reengaged in nonfatal suicide.

Unsolicited encounters with suicidal men provided health services with a critical "window of opportunity" for altering help-seeking behavior. As participants' narratives indicated, encounters with a health professional who adopted a person-centered approach tended to activate help seeking. David's story illustrates this point. David came into contact with a social worker, Lara, during a subsequent hospital stay for suicidal injuries. On this occasion, he had taken a medication overdose and tried to shoot himself. Lara avoided a mental illness framing of David's difficulties, instead exploring the underlying social and personal issues he raised. David described Lara as "respectful." He felt able to discuss the devastating effects of the AIDS epidemic on his social networks and his unresolved feelings of grief. David's interactions with Lara also altered his view of health services. He began to actively seek appointments with Lara and willingly engaged in the interventions that she suggested. He said,

> I would tell her everything and anything. All my problems or anything that I was having difficulty during the week. And I would often go in there and say, "Look, Lara I feel like killing myself today," but she was able to come to the forefront and soothe me down a bit. But anytime up before Lara, I mean, it was, as I said, it was hopeless. Nobody was there to help me.

It is important to point out that, although David's case was seemingly intractable—he had engaged in nonfatal suicide on multiple occasions—a person-centered approach was significant in resolving David's emotional distress and suicidality. David believed that earlier intervention of this kind would have saved him considerable personal suffering.

For some participants, it was not the case that health professionals pathologized suicidal feelings, rather suicidal distress was completely overlooked in health services. For example, Andrew came into contact with health services when he was 19 years old following a fall and serious injury to his leg. When treatment was unsuccessful Andrew's leg had to be amputated. Following surgery he became increasingly distressed and suicidal. Yet during his hospital stay he received very little psychological support,

> It's funny, the whole [hospital] process is: have the accident, try to save it [leg], take it off, do your rehab, get fitted for your leg, learn to walk and that's sort of it. At no point through that process, whether it be physiotherapy or in the ward, does anyone come and talk to you and say, well you know, how you feeling about this? It may have made a difference. It probably would have made a difference. I only saw one psychologist in the whole period that I was in there, they came in and asked me a few questions and you know, I was quite boisterous, oh you know, don't worry about it, it'll be okay and that was the first and last time I'd seen anyone.

For Andrew, expressing emotional distress was extremely difficult because, as he put it, "it's emasculating." Although he wanted to "open up" Andrew brushed off the psychologist's attempt to assist. However, the psychologist, who took Andrew's response at face value, was inadvertently complicit in maintaining Andrew's socially masculine pattern of emotional concealment. This supports Courtenay's (2000) assertion that health professionals frequently fail to recognize health issues in male patients due to dominant notions of masculinity. The failure of health services to recognize, and act on, suicidal distress in men can have serious consequences. Andrew engaged in nonfatal suicide shortly after leaving hospital, overdosing on pain-relief medications. Although Andrew survived, at the time of the interview, he was again planning suicide and was referred to support services.

"Not Too Manly": Actively Avoiding Health Services. The data indicated that some men (N = 3, 17%) consistently followed the pattern of avoiding health services suggested by Cleary (2005). Three men actively avoided seeking help and had no contact with health services. Participants' reasons for avoiding services related to their views around masculinity as well as to their perception of health services. This is illustrated by Ken's case. Ken, who tried to kill himself by jumping from a well-known suicide spot when his business went under, actively avoided health services. He was afraid that his personal distress would be framed as mental illness. Indeed, he believed that visiting a health professional to discuss emotional issues was something that only "crazy people" did. He also believed that seeking help was, in his words, "not too manly." Although Ken's pattern of avoiding health services supports dominant notions regarding men help seeking, it is important to note that this was the least common pattern among participants. It is also the case that men's reasons for avoiding services related to the *realistic* assumption that a clinician-centered approach would be encountered.

"Gender-Friendly" Rather Than "Male-Friendly" Services. There was no evidence that participants in this study believed that services were feminized or in any way favored women. Three men (17%) did, however, comment directly on the failure of health services to explore the dynamics of masculinity. Liam's case exemplified this kind of narrative. Liam struggled to come to terms with his attraction to men. He desperately wanted to maintain the appearance of, as he described it, "respectable heterosexual masculinity." As Rich (1980) suggests, heterosexuality is viewed as "compulsory" for achieving hegemonic masculinity. Liam was acutely aware that coming out as a

gay man would have serious implications for his family, friend, and work relationships. He became withdrawn and eventually engaged in nonfatal suicide by hanging.

Later, when Liam eventually—and actively—sought help from a primary care physician, he was referred to cognitive behavioral therapy (CBT). Although Liam found this psychotherapeutic intervention useful for understanding and managing distressing thoughts and emotions, he was frustrated by the focus on personal transformation. As he so succinctly put it,

> CBT has its limitations. Where you have a complex issue such as sexuality, yeah, which is entwined with the greater society, it's [CBT] like having a little scooter and saying, like now you have to go to Sydney from Perth.

For Liam, CBT was clearly inadequate to address the complex and painful process of negotiating the social stigma and discrimination toward gay men. He continued to feel ashamed, isolated, and suicidal. It was not until Liam encountered a community organization for gay men that he was supported to consider his personal experience of shame in relation to wider social processes that constitute homophobia. Liam described the community organization as an "exceptional" source of support, which contributed considerably toward reducing his feelings of suicidal distress.

Discussion

A Substantive Theory of Suicidal Men's Help Seeking

This study used a masculinities analysis to theorize a model of help seeking in suicidal men. The findings from this study do not support a narrow and uniform view of men's help-seeking behavior. Instead, three distinct patterns of engagement with services were identified. First, some men ($N = 6$, 33%) actively sought professional help when they felt they had little to lose. Oliffe, Ogrodniczuk, Bottorff, Johnson, and Hoyak (2010) have observed this pattern of suicidal men hitting "rock bottom" before engaging with services. Unlike Oliffe et al. (2010), this study did not identify that men reframed help seeking as a courageous act, some men did, however, embrace help seeking as a way to restore resources such as paid work. Second, some men's help-seeking practices ($N = 9$, 50%) could be triggered by unsolicited contact with health services. Third, in a few cases ($N = 3$, 17%), professional help was consistently and deliberately avoided. While Cleary (2005) and others have argued that the dominant practice among suicidal men is to avoid health services, this third pattern—of avoiding services completely—was the least common practice in this study. The findings confirm Wenger's (2011) view that men can, and do, engage with health services in diverse ways.

Responsibility for help-seeking behavior did not rest solely with suicidal men. Participants' help seeking could either be facilitated or blocked by the kind of professional support that was available. As Wenger (2011) suggests, there is a dynamic interplay between help seeking and health services. In other words, the kind of services that are offered directly affect men's efforts, and desire, to seek further support.

The majority of services that the study men encountered were clinician-centered, focusing on individual psychopathology. Yet the study participants overwhelming rejected this model of service delivery. This occurred regardless of whether men actively sought help or had unsolicited contact with health services. Indeed, the fear of encountering clinician-centered services was a major deterrent for those men who actively avoided help seeking. Clinicians have previously questioned the value of psychiatric models of care for the management of suicidal behavior (e.g., Hunter et al., 2013). Michel et al. (2002), an international working group of psychiatrists, argue that the clinical focus on psychiatric diagnosis does "little to inspire confidence" in suicidal patients, who commonly failed to attend follow-up sessions (p. 426). Michel et al. (2002) distinguish person-centered care as best practice with suicidal patients. As they contend, a person-centered approach promotes dialogue and has the potential to reduce suicidal feelings. Building on the work of Michel et al. (2002) and others, this study indicates that person-centered care not only promotes dialogue and reduces suicidal feelings but it can also trigger future help-seeking behavior in suicidal men.

This study highlights the need for health services to men to be developed within a critical framework of masculinities. Data from this study indicated that health providers largely approached suicidal distress in gay men as a manifestation of individual psychopathology. This is in spite of a body of research indicating that the hierarchy of relations among men, which constitute homophobia, are implicated in poor health outcomes for gay men (e.g., Kimmel, 1994). Mills (2014) questions the ethics of reframing personal suffering that is born out of social inequality as mental pathology. Indeed, the practice of medicalizing gay men's response to social stigma and discrimination imposes a kind of "psychotherapeutic hegemony" that privileges and reinforces dominant narratives of masculinity—that is, heterosexual men are depicted as normal and resilient. Only community services that were specifically tailored to the needs of gay men explicitly challenged dominant gender narratives. For some men in this study such services were instrumental in helping them overcome suicidal feelings by uncovering the relationship

between their own personal distress and the collective social processes that constituted homophobia.

Implications for Men's Health Services

The medical–psychiatric discourse of suicide continues to dominate the literature and to shape health service response. The findings from this study bring into question the suitability of this approach for services to suicidal men. This is not to say that the medical–psychiatric framework does not offer clinicians valuable insights into suicidal behavior, but that this approach to service provision fails to meet the needs of many suicidal men. It is important that most men in this study did not resonate with this model, and when they encountered it, they abandoned services or were deterred from seeking further support.

The findings suggest that person-centered interventions are more acceptable and helpful to suicidal men, and tend to promote help seeking. There is an increasing drive for person-centered care within current health services from within the fields of psychiatry and mental health nursing (e.g., McCormack, 2001; Mead, & Bower, 2000; Michel et al., 2002). McCormack and McCance (2010) identify the power of medical discourse and organizational culture as major barriers to person-centered practice. Yet, as Michel et al. (2002) note, person-centered practice can, and does, occur in health settings. The fact that some men in this study did come into contact with person-centered services indicates that this mode of practice is not outside the current scope of health professional practice. The capacity for health service response to reduce men's suicidal feelings and trigger help seeking is important. Research suggests that many suicidal men who come into contact with health services do not return for follow-up appointments and later engage in fatal suicide (e.g., Ryan & Large, 2013). While interest in a sociological analysis of suicide dates back as far as 1897 to Durkheim's (1951) *Le Suicide*, relatively few studies have considered the social context of help seeking (Goldston et al., 2008). If men are deterred by services that adopt a medical framework this may affect men's suicide rates. As Joiner (2005) suggested, alienation from social supports is an important factor in a person's decision to suicide. Engaging men in services, by adopting a person-centered framework, has the potential to assist men to turn toward help seeking rather than toward death by suicide.

Given the diverse and dynamic patterns of men's help seeking highlighted by this study, it is also imperative that researchers and health service providers alike adopt a more nuanced understanding of suicidal men's efforts to seek support. As Wenger (2011) suggests, the current focus on men's poor help seeking within the literature may inadvertently reinforce stereotypes about men's health behaviors. Such stereotypes may affect health service provision and health professionals may fail to take advantage of their critical interactions with men.

While there has been much said within the literature and Australian health policy arena about health services being feminized and failing to meet the needs of men (e.g., Macdonald, 2011), this study identified no evidence to support this view. Still it was the case that health professionals continued to overlook the impact of gender power dynamics on mental health. It is imperative that health service providers authentically engage with gender relations theory and learn how to challenge dominant gender narratives, which may block help seeking in some men.

Conclusion

This Australian study of suicidal men's help seeking adds to the field of men's health and masculinities in three important ways. First, it takes us beyond simplistic representations of suicidal men's help-seeking practices. It draws on interview data with suicidal men who had various levels of contact with health services to develop a model of help seeking that takes into account the diverse practices of suicidal men. Second, it reports on the complex interplay between men's efforts to seek support and the character of health services they encounter. The findings point to the significant role of services in promoting, or limiting, help seeking in suicidal men. Finally, the study findings indicate that health services to men need to be developed within a critical framework of masculinities so as to avoid privileging dominant narratives of masculinity.

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