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"You feel like you can't live anymore": Suicide from the perspectives of Canadian men who experience depression

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ABSTRACT

Severe depression is a known risk factor for suicide, yet worldwide men's suicide rates continue to outnumber reported rates of men's depression. While acknowledging that the pathways to suicide are diverse, and being mindful of the complex challenges inherent to studying suicide, we interviewed men who experienced depression as a means to better understanding the processes they used to counter and contemplate suicide. This novel qualitative study provides insights on how masculine roles, identities and relations mediate depression-related suicidal ideation in a cohort of 38 men in Canada, ranging in age from 24 to 50 years-old. Constant comparative analyses yielded the core category of *reconciling despair* in which men responded to severe depression and suicidal ideation by following two pathways. To counter suicide actions, connecting with family, peers and health care professionals and/or drawing on religious and moral beliefs were important interim steps for quelling thoughts about suicide and eventually dislocating depression from self-harm. This pathway revealed how connecting with family through masculine protector and father roles enabled men to avoid suicide while positioning help-seeking as a wise, rational action in re-establishing self-control. The other pathway, contemplating escape, rendered men socially isolated and the overuse of alcohol and other drugs were often employed to relieve emotional, mental and physical pain. Rather than providing respite, these risky practices were the gateway to men's heightened vulnerability for nonfatal suicidal behaviour. Men on this pathway embodied solitary and/or risk taker identities synonymous with masculine ideals but juxtaposed nonfatal suicidal behaviours as feminine terrain.

One of the most striking features of the epidemiology of suicide has been the rise in suicide among men in Western countries (Cantor, 2000). Many factors are implicated in men's suicide, including childhood adversity (i.e., physical and sexual abuse) (Afifi et al., 2008), unemployment, divorce, and substance misuse (Gunnell, Middleton, Whitley, Dorling, & Frankel, 2003), as well as biomedical pathologies including reduced serotonin levels (Szanto et al., 2002). Although varying social and biological determinants can lead men to suicide, depression in severe forms is arguably the highest risk factor (Gonzalez, 2008). The pathways between men's depression and suicide are poorly understood; however, an emergent masculinities literature suggests significant upstream benefits (i.e., suicide prevention) may be derived by unraveling how men who experience depression react to thoughts about suicide or suicidal ideation whereby formulated plans without the suicidal act itself can accompany suicidal thoughts (Addis, 2008; Oliffe & Phillips, 2008).

Depression, suicide and masculinities

Various masculine identities, roles and relations are implicated in men's depression. For example, depression can emerge as a by-product of divorce whereby men are dislocated from provider and protector roles, and their primary relationship[s]. Unemployment can create disarray in masculine career and breadwinner identities derived from paid work and job prestige to trigger or exacerbate depression. Men's depression-related reactions are also influenced by varying alignments to masculine norms. For example, men who avoid help-seeking and subscribe to stoicism and self-reliance can be perceived as typically male, yet privately harbour a depression (Mansfield, Addis, & Mahalik, 2003). Reluctance to seek help for depression is especially common in men because it signals vulnerability, attracts significant stigma, and directly contradicts the strength and power synonymous with masculine ideals (Real,

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1997). In sum, depression is a decidedly unmasculine ailment (Branney & White, 2008), as is seeking help for what is routinely positioned as a woman's disease (Riska, 2009).

It is in the nexus of men's self-management and reluctance to seek help that empirical insights connecting Connell's (1995) masculinities framework to depression are detailed. A study of 14 US-based men, ranging in age from 30 to 51 years, diagnosed and treated for major depression revealed how participants minimized the damage to their masculine self-concept by delaying treatment-seeking while disconnecting from others, amid self-blame for not being able to 'overpower' depression (Heifner, 1997). A secondary analysis of 16 UK-based men's interviews indicated that, rather than admitting to having depression and/or seeking help, participants self-monitored and treated themselves with a range of 'coping' behaviours dedicated to passing as 'one of the boys' and re-establishing control by taking or resisting medication and fighting depression (Emslie, Ridge, Ziebland, & Hunt, 2006). An Australian-based grounded theory study revealed processes of 'acting in' and 'acting out' among male teachers and students ($n = 77$) who discussed their experiences of being 'down in the dumps' and how they managed symptoms (Brownhill, Wilhelm, Barclay, & Schmied, 2005). The process of 'acting in' referred to men's avoidance of problems by not thinking about them, purposely forgetting, distancing themselves by doing other things and/or trying to numb distress with drugs and alcohol. These strategies could lead to a buildup of negative emotions, resulting in men 'acting out', through risk-taking, violence, aggression, and crime. Finally, 'stepping over the line' detailed the potential for men's self-harm and suicide. The authors concluded that traditional notions of masculinity were implicated across the 'big build' processes they described (Brownhill et al., 2005).

Suicide is the outcome for more men than women (Rudmin, Ferrada-Noli, & Skolbekken, 2003) and this longstanding pattern inadvertently positions suicide as masculine, and nonfatal suicidal behaviours as feminine attention-seeking terrain (Canetto, 1997). Masculinities have also been linked to risk factors for suicide, the means by which men engage in suicidal behavior, and whether they survive (Payne, Swami, & Stanistreet, 2008; Rutz & Rihmer, 2007; Scourfield, 2005; Swami, Stanistreet, & Payne, 2008; Synnott, 2008, 2009). For example, characteristics of traditional masculinity including independence, assertiveness, leadership, and dominance have strong correlations with suicidal thoughts in middle-aged men (Hunt, Sweeting, Keoghan, & Platt, 2006). Solitary discourses around masculinity render men less socially connected, supported and networked than women, leaving them vulnerable to social isolation – a known risk factor for suicide (Houle, Mishara, & Chagnon, 2008; Murphy, 1998). Men who align with masculine ideals are also more likely to engage maladaptive coping strategies, including alcohol and drug overuse (Möller-Leimkühler, 2003), and these are known complicating factors in depression that can lead to suicide (Groves & Sher, 2005). Men's use of fast, violent methods (e.g., firearms, hanging) are distinctly masculine means to suicide (Hawton, 2000; Kerr, Owen, Pears, & Capaldi, 2008), and media stories detailing suicide are known risk factors for vulnerable men (Coyle & MacWhannell, 2002).

Connell's (1995) framework positions a plurality of masculinities as intersecting with age, history, culture, class, and religion, whereby men's productions of gender are influenced by dominant masculine ideals. However, Galdas, Cheater, and Marshall (2005) and Seidler (2006) argue that Western masculine ideals do not necessarily transcend and/or subsume cultures. Instead, varying locally specific practices emerge as idealized within and across men's lives (Lohan, 2007; Oliffe, 2009). Connell's (2005a,b) work in globalized masculinities affirms the merits of focusing on the specific locales and emergent evidence linking masculinities to nonfatal suicidal behaviour and includes Cleary's (2005) study of young 52 Irish men. Revealed in this study were the constraining influences of hegemonic masculinity in men's "highly rehearsed and rigid performances" (p. 174) for maintaining silences around distress, reluctance to disclose emotional matters, and concealing their plans for suicide (Cleary, 2005). In a life course study of two Australian men, Dunn (2008) described how participants' estrangement from masculine ideals around employment and marriage mediated their nonfatal suicidal behaviours.

Consensus prevails among commentators and researchers that men-centered suicide prevention strategies are needed, especially for men who have known risk factors (Owens, Lambert, Lloyd, & Donovan, 2008). With this in mind we explain how, among men who experience depression, masculinities are intertwined with their reactions to suicidal ideation as a means to thoughtfully considering gender-savvy strategies for advancing men's mental health.

Methods

As Ridge (2009) eloquently suggests, depression is often a chronic ailment of interiority, which ultimately means that men who experience depression can provide important illness insights. Qualitative interview studies have described connections between masculinities and men's health practices, such as help-seeking (O'Brien, Hunt, & Hart, 2005), and/or illnesses including prostate cancer (Chapple & Ziebland, 2002; Oliffe, 2005). Similarly, we began an interview study focused on men's depression, but early on in the data collection phase we were struck by the details participants shared about suicide. Rather than re-orienting participants to our focus on depression, or delinking depression from suicide in our analyses we adapted a grounded theory design and constant comparative analytic logic (Charmaz, 2006) to detail the processes and pathways used by men who experience depression to counter and contemplate suicide.

Sample

Thirty-eight men ranging in age from 24 to 50 years ($M = 36.2$) who self-identified ($n = 13$) or were formally diagnosed ($n = 25$) with depression participated in the study (See Table 1 for demographic data). Participants resided in Vancouver ($n = 20$), a city of ~2.5 million in Western Canada, and Prince George ($n = 10$), a remote urban centre in Northern British Columbia (BC) with a population of ~77, 000, and Kelowna ($n = 8$) a regional city of ~165, 000 people in

Table 1
Participant demographics.

	n	%
Highest level of education attained		
< High school	4	10.5
High school diploma	7	18.4
Trade	4	10.5
Some college	1	2.6
Completed college	19	50
Graduate school	3	7.9
BDI Score[a]		
Minimal depression (0–13)	7	18.4
Mild depression (14–19)	9	23.7
Moderate depression (20–28)	8	21.1
Severe depression (29–63)	14	36.8
Treatment for depression (current and/or past)		
No current treatment	14	
Counseling/Therapy	16	
Medications	29	
Group Counseling	7	
Cognitive Behavior Therapy	4	

[a] Beck Depression Inventory (Beck et al., 1996).

Southern BC. Most participants were heterosexual ($n = 35$) and all but 3 men had a partner. Participants self-identified as Anglo-Canadian ($n = 30$), First Nations ($n = 3$), European ($n = 3$) and Asian ($n = 2$); 26 were employed in a variety of unskilled, semi-skilled and professional jobs in a full or part-time capacity, and 12 were unemployed. Although details about income were not collected, most participants ($n = 28$) indicated that they endured significant financial hardship. Participants were representative of subordinate masculinities by virtue of the depression and suicidal thoughts they experienced as well as the conditions invoked by their illness.

Data collection

Both University and Hospital ethics approval (from RISE at the University of British Columbia; University of Northern British Columbia; Northern Health and Frazer Health) for each of the three recruitment sites ensured that the study protocols and procedures were clearly laid out and followed to minimize any potential for participant harm in discussing such sensitive and ordinarily private illness issues (Oliffe, 2010). Postcards, brochures, flyers, and newspaper advertisements were used to describe the study and invite potential participants from the three locales to contact the research staff. The aims of the study were explained to the participants and following completion of a written consent form, individual in-depth semi-structured interviews lasting 60–90 minutes were conducted at a location and time of the men's choice. The data were collected from 2008 through 2009. It was explained that the interview was not intended as a form of therapy but rather as an opportunity for us to better understand men's depression-related experiences. Trained female researchers and the first author conducted the interviews, and participants received a nominal honorarium of C$30 to acknowledge the time spent and their contribution to the study. Demographic data were collected and depression was measured at interview using the Beck Depression Inventory (BDI-II: Beck, Steer, & Brown, 1996) (see Table 1). Although an interview guide was used, participants were encouraged to share details about what was most relevant to them, and conversations rather than questions and answers were encouraged (Oliffe & Mróz, 2005). A printed list of mental health service resources was made available to the participants, and interviewers had specific guidelines for ceasing interviews and referring interviewees to professional services if they observed any participant distress. The digitally recorded interviews were transcribed verbatim excluding any identifying information, reviewed for accuracy, and labeled with an identifier code.

Data analysis

Analyses of the interview data were guided by the constant comparative methods applied in grounded theory. The analytical process involved coding and constant comparative analysis as described by Strauss and Corbin (1998); 'tools' that have been widely used in exploratory qualitative research studies seeking to explore and describe social situations and to understand social phenomena. Although the overarching research question was focused on men's experiences of depression, participants routinely discussed suicide and, based on the details shared in the early interviews, we added interview questions to formally solicit men's commentaries about suicide-related issues (see Table 2). As data collection progressed, interview questions were further refined to address and test the emergent findings derived from the analyses. Data was uploaded and organized using NVivo 8™. Initial coding involved making comparisons between transcripts, searching for similarities and differences, and then labeling similar phenomena as open codes. Second-level coding focused on making propositions about connections between open codes and reassembling them into 'tentative themes' to form a more precise and complete explanation of the phenomena (Strauss & Corbin, 1998). The 'tentative themes' were discussed by the research team on several occasions until a consensus on the interpretation of patterns in the data was reached. Consistent with grounded theory, memos were developed to detail and define processes, paying attention to the contexts and instances within the data to inductively derive a model depicting the pathways for countering and contemplating suicide.

Table 2
Interview Questions Related to Suicide.

Sometimes people with depression have thoughts of suicide. Has this ever happened to you?
• How did you react?
• What are the triggers for thinking about self-harm?
• How detailed do the thoughts become?
• Most recent incident?
• Who did you disclose these details to?
• Why this person? Specific details disclosed?
• Have you ever known anyone who has suicided?
• How did you react?

Findings

Reconciling despair

The onset, cause and triggers for participants' depression varied. Some men had harboured signs and symptoms of depression in childhood and teenage years while others, without warning, experienced an acute depressive episode later in life. However, it was amid unrelenting emotional, mental and physical pain; failed medical and/or self-management; and escalating relationship and work dysfunction that men's depression induced despair demanded action. As such *reconciling despair* was identified as the basic social process underlying men's experiences. Typically men's problem-solving abilities faltered and mounting stress and anxiety reduced their functionality and productivity, as explained by a 43-year-old courier driver:

> As soon as I see some problems come up, you worry and then it makes you depressed and you say 'gosh', you know, 'how am I going to solve all those problems' and then you feel like…you just want to die…you know, you, feel like you can't live anymore.

With varying circumstances and thresholds, participants became disabled and went about reconciling their despair by seeking relief from the conditions that severe depression had invoked. As illustrated in Fig. 1, two pathways emerged. In one pathway men countered their suicidal ideation by connecting with others as a means to dislocating their depression from self-harm in sustainable ways; by contrast, contemplating escape revealed solitary practices that brought men closer to self-harm and nonfatal suicidal behaviours. It is important to note that the two pathways were not mutually exclusive, nor did they necessarily operate in a linear or unidirectional way; however, they are presented chronologically in the findings that follow to detail the underpinning processes.

Countering by connection

Participants detailed how, by drawing on established connections to family and peers, as well as religious and moral beliefs, they were able to counter suicidal thoughts. Most prominent were intimate partners who, as Swami et al. (2008) predict, inhibited

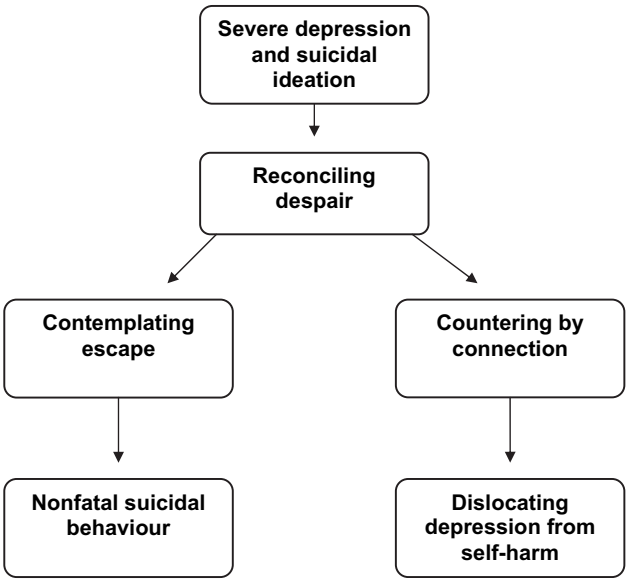

Fig. 1. Conceptual model detailing men's countering and contemplating suicide.

men's suicide by providing participants with an important source of stability and emotional support. The men's linkages to partners played out in a variety of ways, and a 37-year-old lawyer explained how action-orientated spousal support gave him much needed direction and assurance in a time of crisis:

> She [wife] was always very action focused and solution focused, saying, okay, what do we need to do, how do we get past this…knowing that she was there, always gave me hope, and always gave a focus to my life even when there wasn't anything else to focus on.

This man revealed his partner's embodiment of traditional feminine caregiver roles in which women look after the health of the men in their lives, as previously detailed by Lee and Owens (2002). However, also evident were shifting power relations whereby feminine strength and problem-solving surfaced to aid, compensate and perhaps reorientate men's ailing or injured masculine identities. Such gender relations can create a sense of obligation and sometimes guilt. A 42-year-old English teacher acknowledged that his behaviours and severe depression had negatively impacted his wife and their relationship in assuring us that he would resist urges to suicide in an effort to avoid hurting her any further:

> I still feel suicidal now but I also feel a burden of guilt and that's what stops me because I've put her [wife] through so much.

Although there is masculine deviance in 'needing' human connections, Synnott (2008) suggests they can foster prudence and cooperation to waylay men's concerns about possible failures, which in turn reduces the possibility of suicide. This was also apparent in our study, yet approximately three-quarters of the participants consistently represented their masculinity within these 'connecting' contexts. For example, men embodied strong desires to be a good partner, family man and father, and recognized that suicide constituted both abandonment and the infliction of pain on loved ones. So sturdy were family ties that men remained stalwartly committed to enduring depression, regardless of how severe it became. In these ways, idealized masculine roles emerged as shielding, in that men's allegiance to provider and protector roles sustained their fortification and mobilized assurances that reneging on their responsibilities through suicide would be a decidedly cruel and unmanly action.

Embedded here are well-known masculine practices in which men 'do health' and/or avoid risk for the benefit of others, especially family (see Johnson, Oliffe, Kelly, Bottorff, & LeBeau, 2009). These family and partner-centric constructs for taking up self-health also emerged within a masculine arena, whereby men's salvation was mediated by obligations to others. This was illustrated by a 37-year-old unemployed man whose concern for family (as distinct from self-care) mitigated any plans for acting on his suicidal thoughts:

> It seems like a doorway, it's like a doorway that I know I can't go through. I can't do that to my parents, I can't do that to [wife], I can't do that to my brother, but I so much would just like to go to sleep and not wake up.

Participants' accounts of admitting suicidal thoughts to others implied relinquished solitary and stoic masculine ideals, and the trepidation men had in self-disclosing was linked to the incongruence of their actions with what men typically do. Yet, instead of weakness or a counter-hegemonic project, connecting was justified as the wise, rational charge to safeguard survival. A 42-year-old English teacher confirmed the benefits of connecting with others:

> There's always someone somewhere who cares it seems, you know, in the deepest, most despairing moments. Humans are humans, they don't want to see other people get hurt so I would say reach out, you're not tough, even though it's embarrassing, you feel guilty, you feel weak but it's the best thing to reach out for help, I think, now after having done so. But I still feel at times suicidal but I'm just glad that I'm here.

Therefore, connecting with others held strong potential for preserving rather than threatening men's masculinity. For example, not giving into suicide but instead embodying the good fight was consistently referenced by participants. Rather than taking the easy way out, a 44-year-old unemployed man was focused on finding a job as the lynchpin to reclaiming his breadwinner status and subverting his suicidal thoughts:

> I know I'd never actually take my own life…I guess I just think about it a bit more often now, especially like not working and stuff, I have too much free time…I toy with the idea, but then I just put it away, that'll be too easy.

Men also drew on their religious affiliations and moral beliefs in countering suicide. The aforementioned 44-year-old unemployed man explained "I'm also Catholic, you can't quite commit suicide. I don't feel like burning forever". Similarly, a 42-year-old unemployed man was "not afraid to die" but quipped, "I won't kill myself cos it's a sin, I am not a religious man but I don't want to explain that when I get there, I owe enough explanations to people". Fears about transgressing beliefs featured as prohibitive for taking ones' life. Such spiritual and philosophical connections provided additional avenues for asserting selflessness, loyalty and discipline in choosing not to act on suicidal thoughts. While the masculinities and help-seeking literature has focused on men's engagement with professional health care services (O'Brien et al., 2005) our findings reveal an array of potential sources from which men who experience suicidal thoughts can draw solace. That said, the diversity, and in part the efficacy of these resources was contingent on men's insightfulness and willingness to acknowledge and receive some support in addressing a significant problem.

Dislocating depression from self-harm

Although connecting with others blocked suicidal actions, in order to advance that position to disarm thoughts about suicide in sustainable ways, participants mobilized additional strategies. The cognitive dissonance for men in thinking about, but not wanting to

suicide was addressed through recognizing the presence of a depression that required ongoing management. Accessing resources, including health care providers, either for treatment[s] and/or as a conduit to mustering effective self-management strategies was evident among approximately two-thirds of the participants. A 42-year-old inpatient who we interviewed on a psychiatric ward following a recent nonfatal suicide episode concluded that prevention for him was contingent on being able to debrief with health care providers and/or friends:

> I just realized that there's someone out there that usually will listen and basically that's what most people need is just to have someone listen and get something off their chest and they'll take a step back from suicide…someone to hear you out.

This participant went on to detail plans for ongoing medical treatments to ensure he did not fall back into despair, and self-harm. A 26-year-old homemaker also positioned his self-disclosing talk as therapeutic, "it just helped me to talk about it [suicidal thoughts] a little bit…but…it's not like I felt like I would get sucked into this black hole". A 26-year-old laborer bared the unexpected centrality of another man in arresting his suicidal thoughts:

> I'd call him up 'now, I'm not thinking right' and he'd say, 'you know what man, things will get better', he's had suicide training right, so he knew how to bring me down. He'd say, 'come over to my place, you shouldn't be alone right now', so I'd go over there and we'd kick it and talk, play games, watch movies. I really, I don't know, I never had male friends.

Connell (1995) suggests dominant ideals of masculinity depict emotional expression as weak and feminine, and Pease (2002) confirms that men are especially likely to hide their feelings for fear of exposure and ridicule from other men. Yet dislocating depression from self-harm showed how men could transgress these masculine norms, albeit in manly ways. Such distinctions between masculinity and manliness date back to the nineteenth century (Tosh, 1994) whereby manliness can be about moral excellence (i.e., resisting self-harm), as likely found in a weak (i.e., depressed) body as a strong (Hughes, 1880). The aforementioned examples also expose men's talk as measured and therapeutic rather than as unintended, uncontrolled emotions that might signal the loss of rational thought (Galasinski, 2004). The permission of others to disclose details about their feelings was also strategic to participants normalizing that dialogue as a legitimate form of assistance and self-help tactic.

A change in course and some reframing about what it is to be a man also enabled some participants to accept more formal professional help. Masculine ideals about denying illness and evading professional help were acknowledged as risky scripts that needed to be avoided. A 37-year-old lawyer's observations of a psychiatric ward in which he had been an inpatient led him to suggest that, in most cases, women were admitted on a voluntary basis whereas men had to be involuntarily committed:

> It's the culture of the stoic warrior and all that kind of thing…we just don't, it's not okay to ask for help, it's not okay to admit any kind of weakness, um, and that by pushing, by men pushing themselves away from getting help it's more likely to be worse by the time they do ask for help.

Men's help-seeking or assertions that they had received the life-saving help they needed afforded various productions of masculinity. For example, actively seeking help could be interpreted as contravening masculine ideals related to strength and autonomy. However, it was evident in the men's graphic accounts of reaching rock bottom before eventually seeking help to courageously confront their demons, or receiving unsolicited help in a do or die situation that idealized masculinity could be represented. For example, admitting a problem and seeking help were positioned as a brave enterprise, and receiving life-saving assistance afforded compelling tales of men's resilience amid justifications that specialized resources were needed to combat a potentially deadly disease.

For most men, self-management directly drew upon and/or was an important adjunct to medical treatment[s]. A 34-year-old journalist described how the foundations of cognitive–behaviour therapy enabled him to deconstruct his thought patterns to better understand, anticipate, and modify suicidal thoughts:

> There are always those two viewpoints: when you're in and when you're out. And eventually you see enough from the outside, when you're going okay, here's the pattern and 'oh it didn't really work out this day'…So it's like 'why am I feeling this way today?', well let's look back.

Introspection as the conduit to effective self-management was a control measure whereby men could consciously reset their thinking to quell thoughts of suicide. So, although participants continued to experience suicidal thoughts, their impulses to execute them were effectively constrained. A 26-year-old carpenter suggested vigilant monitoring and self-talk were fundamental to disarming suicidal thoughts:

> When I think about depression, I think about suicide but I don't think about myself ever really killing myself because I think, and then I don't want to be at that point so I always think about it but I don't actually think about doing it. But I feel it gets to the point where I really feel completely…just worthless sometimes but I tell myself don't start thinking about suicide.

A rational decisiveness was portrayed by approximately one-half of the men in knowing when and how to self-manage and counter suicidal thoughts. As Emslie et al. (2006) previously found, it was clear that generalizations about men always being strong and silent in the face of mental illness reflect simplistic versions of a complex story. Indeed, our findings indicate that masculine ideals can emerge as a mediator for, and outcome of effectively managing suicidal thoughts.

Contemplating escape

Contemplating escape encompassed diverse circumstances that had drawn men closer to risky practices and self-harm as a means to reconciling their despair. Crises were detailed by more than a third of the participants in which their hopelessness was fuelled by dislocated self-management strategies and estrangements from actual and potential supports. Some men detailed lifelong failures while others, including a 37-year-old construction worker, had attained various masculine signifiers, only to lose them as a by-product of severe depression:

> I have three daughters, I was married, bought a house, had all that and it just all slowly slipped through my fingers, you know, I was getting depressed, nightmares all the time, couldn't function, couldn't get up in the morning anymore, finally my girlfriend said 'that's enough', she kicked me out and I was homeless.

In this, and similar accounts, men had fallen from, or failed to reach a variety of masculine ideals and were left to operate as the antitheses of idealized masculinity –weak and without worth, abandoned yet in need of help. Relationship dysfunctions as well as break-ups isolated men and maladaptive practices emerged to

increase the potential for self-harm. At the extreme, the relationship complexities of a 37-year-old unemployed crack user distilled how suicide could result from staying with, as well as separating from his partner who was an intravenous drug user and experienced mental illness:

> With this relationship and the way things are, I'm so worried that something I'm going to do is going to cause her major strife in her life. So now I feel I'm in this catch-22 where I can't leave; if I kill myself that's going to screw her up, if I stay and we continue this co-dependant relationship and we don't get help and all this stuff, I'm going to drag her down or she's going to drag me down or we're going to drag each other down.

As Robertson (2007) previously found, women can negatively impact the health of their male partners, and participants highlighted their propensity for self-harm as contributing to, and/or resulting from relationship dysfunction. The loss and grief associated with faltering or failed relationships was usually entangled with other factors. For example, a 25-year-old student who left a girlfriend that he "wasn't happy with", began drinking excessively and kept "recycling these thoughts about suicide and how to do it, what's the best way?" A 44-year-old unemployed man wanted to avoid the public shaming he predicted would accompany being known as a father who didn't work and was ineligible for government assistance, but pointed to the futility of using alcohol and drugs to blunt his fears:

> I'm going to get cut off of employment insurance pretty soon, and everybody is going to find out. So I was getting kind of suicidal at the time and I was looking for ways of getting out of having to own up to my responsibilities as a man and when I started feeling like…I wasn't being up to standard I started looking at ways out with drugs and alcohol giving me a temporary way out and eventually coming back there was, there was always suicidal thoughts.

The substitution hypothesis detailed by Riska (2009), in which rather than taking medication men self-medicate stresses and anxieties with alcohol and drugs, was a common practice among participants contemplating escape. Further, alcohol and drug overuse are celebrated productions of masculinity (Kimmel, 2008) which can bolster mood and self-confidence to dissipate men's despair. However, as Groves and Sher (2005) predict, the men in our study gained little respite through alcohol and drugs but, instead, their suicidal thoughts remained and often escalated and intensified.

Participants were also reticent to discuss their suicidal thoughts and/or plans with health care providers. A 25-year-old student insisted suicide was "not really something you talk about" and when counseled he was careful not to reveal his suicidal ideation:

> One thing that I had never really mentioned in counseling was the suicide. And how I was feeling depressed and suicidal because I was afraid they'd call the cops. And they'd let my parents know. They'd say I was a danger to myself.

Similarly, a 42-year-old unemployed man who had been incarcerated for two decades suggested admitting suicidal thoughts to health care providers would further disempower and marginalize him:

> Well, most health care providers if you go to them and say that you've had suicidal thoughts and you think about suicide, you would have to be worried about what they would do and what type of buttons they might be pushing when your back is turned.

Amid social isolation and disconnects from health care services, men craved escape in ways that romanticized suicide as a viable and preeminent option. The cumulative fatigue of unsuccessfully trying to dissect or intersect negative thoughts, and the anguish of dysfunction and every day underachievement led men to harbour a death wish. A 25-year-old student explained his "underlying hope" was that suicide would allow him to "start anew" and secure an "existence that would in some way be better". Also, present were men's desires to numb or end their pain, as a 37-year-old unemployed man who was living in an addiction treatment facility explained:

> It's not that I wanted to die, It's just I wanted to stop feeling. It's quite maddening when you feel depressed and you can't get over it… It's not so much that you consistently think about why you're depressed, you consistently think about why everyone else isn't; you don't understand why it hurts to wake up… I just want it to be over.

At various points, suicide-related talk rather than action was interpreted as further evidence of a weak character and failed masculinity. A 43-year-old unemployed man quipped "I don't have the balls for it" and a 39-year-old forestry worker critiqued his failure to drive into an oncoming truck as a by-product of being "chicken shit". Predominant across men contemplating escape was escalating despair and menacing preoccupation with suicide suggestive of high risk for self-harm. As Synnott (2008) advises, it is the quality of life that counts for most men, not the quantity, and cumulative loss and grief underpinned men contemplating escape.

Nonfatal suicidal behaviours

While all the participants linked depression to suicidal thoughts and/or plans, six men shared details about their nonfatal suicidal behaviours. A 37-year-old unemployed man had a long history of nonfatal suicidal behaviours which he positioned as conflicted actions and cries for help rather than reflecting his lack of competence in suicide:

> I think I just gave up at that point and gave in…the harder I tried to end my life, it was just the louder I was trying to scream.

His actions emerged as stoic signals reflecting the severity of his pain and inability to articulate it (or perhaps be heard) in a conventional way. A 49-year-old unemployed man detailed his most recent nonfatal suicidal episode, which occurred while he was in custody. He "tied wool blankets together" and put them around his "neck and ankles, tied them up and went to sleep" exclaiming "I didn't feel nothing eh". However, the wardens intervened because "I was turning blue…and the next thing I know…I was in a straitjacket".

Although limited in what we can say about suicide, the men's accounts about nonfatal suicidal behaviours afforded two key insights. First, there was evidence that nonfatal suicidal behaviours could mobilize significant external and internal stigma. For example, a 37-year-old unemployed man who overdosed on his father's medications was found by his girlfriend's children and admitted to an intensive care unit. Despite assurances that she would support him, his girlfriend "kicked me [him] out" of her home amid direct pressure from his own family to leave their small town community:

> I had to actually leave the province, how's that for embarrassment? So before I left, I gave the keys to my truck to my dad and told him to 'fucking keep it', I guess that was my way of saying 'sorry for taking your medication, tried to end my life, hopefully this makes up for trying to kill myself', isn't that ironic, it's sad. I'm here, I have no family, no connection to anybody, I guess that's do or die right?

In this poignant example external social control and censure further ostracized the man, which in turn exacerbated internal shame, blame, fear, guilt, stress, social isolation, low self-esteem, loss of confidence, and negative self-identity (Chapple, Ziebland, & McPherson, 2004). Rather than respite or resolution, the man's despair was amplified by his nonfatal suicidal behaviour. Moreover, suicide re-emerged as an ever present and perhaps inevitable antidote for his predicament. Second, participants suggested that when a man wholeheartedly decides to suicide, there is little that can be done to save him. A 44-year-old unemployed man who had attempted to jump from a bridge assured us that he would never say he was going to hang himself, "simply because then it would be like committing myself to it. And when I commit myself to do something I usually do it". Similarly, a 24-year-old student who denied any direct experience with nonfatal suicidal behaviour suggested prevention initiatives were of little use when a man's mind was made up:

> Both government and the university have hotlines [suicide prevention] so that people can call them and talk to them but that's hilarious to me. No one's going to call them to say he is going to commit suicide. If I want to commit suicide, I just do that. I don't call someone and say 'OK, shall I do that or not?'

As Möller-Leimkühler (2003) found, it was clear that lethal suicidal behaviours were perceived and affirmed as masculine terrain, whereas nonfatal suicidal behaviours had negative gender connotations for many men.

Discussion and conclusion

Novel empirical and methodological contributions are afforded by our study to advance masculinities and men's health research, and more specifically add to the emergent body of knowledge addressing men's mental illness. Our model for reconciling despair provides a framework for understanding how masculinity, men's depression and suicidal ideation can connect. The processes of countering by connection and contemplating escape reveal men as active agents whose productions of masculinity are ever present and entwined with their health and illness practices. Confirmed by our findings are much of Cleary (2005),Cleary, Corbett, Galvin, and Wall (2004), and Dunn's (2008) insights drawn from masculinity studies of men who exhibit nonfatal suicidal behaviours. Our results also extend the men's depression work by Emslie et al. (2006) to prompt considerations about upstream strategies for advancing the mental health of men who experience depression and, more specifically, preventing suicide in that vulnerable population. Said another way, by describing connections between masculinities, depression and suicide, insights to men-centered solutions as well as gender-specific problems can be garnered.

Our findings affirm that approaches to depression and suicide prevention that specifically address masculine practices will offer more success than those that are gender-neutral. With regard to primary prevention, public health policy needs to make visible the diverse ways in which men construct ideals and produce masculinities to chronicle the potential for those linkages to increase or decrease men's risk for suicide. For example, doing gender can privilege men's autonomy and foster excessive and impulsive behaviours which restrict their help-seeking and social connections to heighten the risk for suicide. That said, it is also clear that masculine practices (some of which are idealized) can actually mitigate suicide risk. This was evidenced by participants' ability to counter suicide actions by pragmatically repackaging masculinity to meaningfully connect and confide in others as the conduit to effective self-management. By endorsing diversity in masculinities within a broad range of settings alternate scripts for depression and suicide can be made available to men. Similar to the 'Real Men, Real Depression' (Rochlen, Whilde, & Hoyer, 2005) campaign, which linked courage to help-seeking for men's depression, approaches that highlight emotional fitness and mental strength, within a positive and non-stigmatizing framework, and skill development courses that aim to broaden men's self-monitoring and management (e.g., ways to ask for help, recognizing emotions, and mechanisms for emotional management) can appeal to diverse groups of men.

Cleary's (2005) suggestion that nondisclosure and receding opportunities for disclosure can accompany men's escalating fears and anxieties to increase their risk for self-harm and suicide are also supported by our findings. While recognizing the potential for the men who were contemplating escape in our study to avoid professional help, there is evidence that some men who suicide have contact with a primary care provider in the year before their death (Luoma, Martin, & Pearson, 2002). Therefore, targeting education strategies to health care providers can promote greater recognition of the symptoms associated with men's depression, which in turn can reduce suicide rates (Rutz, 2001). It is particularly important to orientate health care providers to how gender is co-constructed in patient-provider consultations, as well as how masculine ideals can mediate men's experiences and expressions in and around depression and suicide. Men rarely disclose details about their suicidal ideations to health care providers. Indeed, some participants in our study were distinctly reticent to speak about suicide with health care providers for fear of punishment or persecution. Therefore, assessments of depression and suicidal ideation should include evaluation of relationship difficulties, losses and social isolation, in addition to work or health-related stresses that are typically presumed to lie at the heart of men's distress.

In terms of methodologies, the ethnographic moment referred to by Connell (1995) more than a decade ago has continued to provide important insights to masculinities and men's health and illness practices. However, a grounded theory approach enabled us to map our findings across discrete and somewhat diverse pathways while avoiding the epistemological and ontological misdemeanors of being perceived to essentialize men's health practices within social constructionist frameworks. This is an important enterprise for two reasons. First, while acknowledging that the passageways to suicide are diverse, and being mindful of the complex challenges inherent to studying suicide, our findings purposely bridged two emergent yet somewhat estranged bodies of masculinities research – men's depression and suicide. Second, by detailing men's alignments to and/or reformulation of masculine ideals as neither entirely risk nor resolution oriented, various masculinities emerge as potential solutions as well as part of the problem. This is not to suggest the abandonment or privileging of particular qualitative methodologies, but rather to highlight how, by focusing on processes, many linkages and potential directions for how and when to effectively support men and/or intervene can be made available.

In summary, our findings avow masculine ideals as flowing between structures and agency to influence men's responses to depression-related suicidal ideation. For example, dominant discourse positions depression as women's terrain and help-seeking for that affliction is similarly anchored in femininities. Inversely, suicide is predominately the action of men and an ever-present masculine option, especially for men whose depression is poorly managed and/or experienced as severe. These relationships bear out in the epidemiological data to reveal men as more likely than women to suicide, even though they are less often diagnosed with depression. The results also expose masculinities as mediating

every juncture in men's pathways toward and away from suicide, and, divisively perhaps, we predict that masculinities feature in the 'black box' manifests detailing the suicides of individual men as well as the disjuncture between men's rates of depression and suicide. By better understanding and mobilizing what we know about how men construct masculinity with particular regard to experiencing and reacting to suicidal ideations, we sincerely hope to help address the problem of suicide among men.

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