



AMERICAN ASSOCIATION OF SUICIDOLOGY

Help-seeking among Men: Implications for Suicide Prevention

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Abstract

With but one exception world-wide, males complete suicide at rates exceeding those of females. The male to female suicide ratio in the United States is greater than 4:1.

Explanatory hypotheses for these findings include gender role behaviors, specifically the greater involvement of men in high-risk health behaviors and the greater propensity of women to seek and use supports for help when in need. This paper explores what is known about gender differences in help-seeking behavior to determine factors that may promote increased help-seeking among men. On the basis of this research, we propose public health intervention approaches that have potential to motivate men at-risk for suicide to seek and receive help.

Keywords: HELP-SEEKING, MEN, SUICIDE PREVENTION

Help-seeking among Men: Implications for Suicide Prevention

The World Health Organization (2002) has estimated that 815,000 people worldwide took their lives in the year 2000. Among those who complete suicide gender differences are almost universally found. On average, worldwide, men were three times more likely to complete suicide as women, but wide variations occur from country to country. Puerto Rico is reported to have the highest male to female ratio (10.4:1). The United States and Canada are closer to the international average (4.4:1 and 3.9:1, respectively); and China is the only country in the world where female rates exceed those of males (1:1.1, see Figure 1). There remains no sufficient explanation for this exception (Schmidtke et al., 1999).

[Insert Figure 1 about Here]

In general, males have a greater incidence of serious health problems and, across all ages, higher rates of death than do females for all the leading causes of death. Much of the explanation for these outcomes lies in the greater involvement of men in high-risk health behaviors. The traditional male gender role encourages risk-taking behaviors as acceptable male conduct (Nicholas, 2000). For example, males have higher rates of cigarette smoking, alcohol abuse, hazardous activities, antisocial behavior, aggression, and violence (Maris, Berman, & Silverman, 2000). Notably, each of these is a correlate or risk factor for suicide.

On the other hand, studies have consistently shown that women have and use social supports more than men (cf., Eisler & Blalock, 1991). Social supports and attachments are significant protective factors attenuating risk for suicide. Moreover, women are socialized to have more complex and flexible coping skills, to accept a more helpless-dependent posture in relationships, and to communicate both emotionally and a need for help (Maris, Berman, & Silverman, 2000). As help-seeking and effective help-getting reasonably are considered preventative of suicide, then women are socialized to behave in ways that relatively protect them from suicide. That women more often choose suicide methods that are less immediately lethal may also suggest both manifest and latent wishes for rescue, a more passive form of help-seeking.

The focus of this paper is to further explore what is known about gender differences in help-seeking behavior specifically as it applies to persons at-risk for suicide. In particular, we wish to determine factors that may promote help-seeking among men and to propose public health interventions that have potential to motivate men to seek help.

There is an extensive body of research that supports the contention that women are more likely than men to seek help for physical, as well as psychological, problems (cf., Tudiver & Talbot, 1999; Blazina & Watkins, 1996; Gianakos, 2000, 2002; Reevy & Maslach, 2001; Moller-Leimkuhler, 2002; Addis & Mahalik, 2003). Many theories have been presented to explain this discrepancy, most of which attribute males' relative lack of help-seeking to conflicts resulting from gender-role socialization (Ashton & Fuehrer, 1993; Blazina & Marks, 2001; Brooks-Harris et al, Good & Wood, 1995; Mendoza & Cummings, 2001; Simonsen et al, 2000; Wisch et al, 1995). Researchers have also

examined issues that serve to discourage help-seeking among men, in an attempt to determine which aspects of these barriers may make help-seeking least desirable (Moller-Leimkuhler, 2002; Calhoun et al, 1974). Most research concerning men tends to focus on perceived negative attitudes toward and detrimental consequences of help-seeking (Calhoun & Selby, 1974; Johnson, 1988; Zeldow & Greenberg, 1979; Lopez et al, 1998; Reevy & Maslach, 2001). However, little research attention has been given to the positive factors that may serve to motivate men to seek help from others (Gianakos, 2000, 2002).

Gender-Role Socialization

Gender-role socialization has been posited to explain men's underutilization of both interpersonal and professional supports. Specifically, adherence to the traditional male gender role may result in negative attitudes toward help-seeking (Good et al., 1989). Traditionally, men are viewed as strong, independent, and emotionally controlled, while women are seen as weak, nurturant, and emotionally expressive (Barbee et al., 1993). Help-seeking implies, perhaps even requires, a sense of vulnerability, in that the person seeking help is dependent on the person from whom help is sought (Lee, 1997). Thus, help-seeking is antithetical to the masculine gender role, and seeking help may be avoided as a result of gender-role conflict.

Gender-role conflict "occurs when rigid, sexist, or restrictive gender roles learned during socialization result in the personal restriction, devaluation, or violation of others or the self" (Good & Wood, 1995, p. 70). Four factors associated with gender-role conflict have implications for men's help-seeking attitudes and behaviors: (1) success, power, and

competition, (2) restricted emotionality, (3) restricted affectionate behavior between men, and (4) conflict between work and family relations (Blazina & Watkins, 1996). For example, “restricted emotionality” --the reluctance and/or difficulty men have in expressing their feelings -- may be indicative of why men are hesitant to seek help from others (Good et al., 1989).

Gender-role conflict may play an important role in a man’s decision not to seek help (Wisch et al., 1995; Good & Wood, 1995; Simonsen et al., 2000; Mendoza & Cummings, 2001; Blazina & Marks, 2001). Wisch et al. (1995) studied the impact of gender-role and counseling technique on help-seeking among men. Participants viewed counseling sessions that used either emotion-focused or cognition-focused interventions. Men who scored high on gender-role conflict reported more negative attitudes toward help-seeking than men who scored low on gender-role conflict. Those who viewed the emotion-focused counseling session reported the least favorable attitudes toward help-seeking.

Good and Wood (1995) found that there are two components to gender-role conflict that affect depression and help-seeking in different ways. Restriction-related gender-role conflict, which reflects a limiting of both male friendships and emotional expressiveness, predicted more negative attitudes toward help-seeking. Achievement-related gender-role conflict, which reflects a drive for achievement accompanied by an evaluation of one’s comparative degree of achievement, predicted more depressive symptoms.

Simonsen et al. (2000) found that gay men who reported less gender-role conflict had more positive attitudes toward help-seeking and experienced less anger, anxiety, and

depression, in comparison to gay men who reported more gender-role conflict. Mendoza and Cummings (2001) studied the relationship between gender-role conflict and help-seeking in male batterers who tended to be “over-socialized or adhere strongly to traditional male norms” (p. 833). They found that men who had higher scores on feeling connected to all men tended to have lower scores on help-seeking attitudes.

Finally, Blazina and Marks (2001) found that men who scored high on gender-role conflict had more negative reactions to all types of treatment, rated a men’s support group as the least desirable treatment, and saw the therapist/facilitator as significantly more powerful than men who scored low on gender-role conflict.

In summary, men may be more reluctant to seek help when it is emotion-focused versus when it is cognition-focused. In this regard, the perceived dynamics of a men’s support group, i.e., specifically disclosing feelings to others in a group setting, may be viewed as undesirable to those who are gender-role conflicted because they run “counter to normative male socialization” (Blazina & Marks, 2001, p. 303). Second, restriction-related aspects of gender-role conflict (“real men are not supposed to feel...”) may predict more negative attitudes toward help-seeking while achievement-related aspects of gender-role conflict (unattainable expectations) may predict more depressive symptoms in men. Correspondingly, making help-seeking and help-getting an attainable expectation may reduce gender role-conflict. Third, men who feel connected to other men through traditional male gender roles may be more reluctant to seek help than men who do not have this connection or men who are well connected to women (see below). Finally, help-seeking may be viewed as diametrically opposed to the traditional male gender role in that it requires a man to be vulnerable and to relinquish power to another.

Decreasing the influence of these restrictive masculine norms or, alternatively, increasing the normativeness of help-seeking are essential aspects to increasing help-seeking behavior among men.

Socio-cultural Differences in Help-Seeking

Certain socio-cultural factors, specifically race and age, distinguish those who seek help from those that do not seek help (Broman, 1987; Cheatham et al., 1987; Lin et al., 1982; Husaini et al., 1994). Broman (1987) found that African-Americans were more likely than Caucasians to seek help from professionals. However, different patterns were noted by race: African-Americans sought help from mental health professionals for their economic and physical health problems and from other professional sources, such as lawyers, teachers, emergency rooms, and social workers, for their problems; Caucasians sought help from medical professionals and clergy members for all types of problems.

Cheatham et al. (1987) found that African-Americans reported a greater number of personal problems and tended to make more external attributions for their problems than did Caucasians. However, overall, there were no racial differences found in help-seeking behaviors. Therefore, gender may be a more salient predictor of help-seeking than race.

Lin et al. (1982) found that family dynamics within certain cultures may influence help-seeking. Specifically, Asian-Americans and African-Americans indicated more extended family involvement and relied on extended family support resulting in a delay in seeking help from professional sources relative to Caucasians.

Husaini et al. (1994) found that elderly African-American and Caucasian females were more likely to rely on prayer and social support for their problems than males of the same race. Less than 20 percent of African-Americans and Caucasians who had received a clinical diagnosis reported using the services of mental health professionals.

Finally, Phillips and Murrell (1994) reported that elderly individuals may be more reluctant to seek help than younger individuals. Their results indicated that the elderly may favor seeking help from general practitioners, rather than mental health professionals, for their emotional problems.

Overall, the research concerning socio-cultural factors suggests that interventions need to consider being designed as culturally-sensitive, particularly targeting family support systems, indigenous and religious supports, and primary care providers as third party referral systems for some racial groups and the elderly who do not appear to first turn to mental health professionals for help with emotional problems.

Social Costs of Help-Seeking

There may be a number of social costs that men associate with help-seeking for both physical and psychological problems (Lee, 1997, 2002; Tudiver & Talbot, 1999; Calhoun et al., 1974). Lee (1997, 2002) identified three social costs: incompetence, dependence, and inferiority that result in a perceived loss of power or control for the person who is seeking help. Incompetence is the result of acknowledging that one is encountering problems or that there is a gap in one's expertise and knowledge; dependence results from asking for another's input to solve one's problem; and inferiority

is the result of acknowledging another's superiority in knowledge, skill and resources for solving one's problem.

Tudiver and Talbot (1999) observed that perceived vulnerability, fear (e.g., of social rejection), and denial were important influences on whether men seek help. In this regard, Calhoun et al. (1974) found that causal attribution may affect the way help-seekers are perceived, i.e., an external attribution of problems (e.g., environmental causes) may promote help-seeking and discourage social rejection more than an internal attribution (e.g., intrapsychic causes) of problems, particularly among working class males. Implied here is that men may be less likely to encounter social rejection and be more likely to seek help if the approach to helping emphasizes an external attribution of problems. Social rejection, in the form of social labelling as being "feminine," may also be perceived or anticipated by men who seek help, as femininity is associated with seeking and receiving emotional support (Ashton and Fuehrer, 1993).

Marcus and Siegel (1982) offered the "fixed role hypothesis" to explain why women may seek help more than men. This hypothesis suggests those who endorse more flexible role obligations are find the sick role easier to adopt. Women, therefore, may be better able to access needed health services because they may have fewer constraints on their time schedules, whereas men may experience more constraints on their schedules due to work-related obligations. Though traditionally sexist in its conceptualization, the "fixed role hypothesis" may explain the rationale that some men use in avoiding help-seeking (i.e., too busy, can't afford to leave work).

Research on the social costs associated with help-seeking suggests that interventions designed to increase male help-seeking need to be aimed at promoting the

social benefits of help-seeking. For example, interventions should focus on help-seeking and help-receiving as involving superiority of judgment, as ensuring competence, and as collaborative. Further, help-seeking should be presented as a legitimate obligation for men to ensure their physical and mental health, thus traditional male roles to procreate, to perform, and to achieve. Interventions should also promote masculinity as an attribute of help-seeking, to augment the likelihood of social acceptability.

Mental Health Problems

Consultation rates and help-seeking patterns in men are consistently lower than in women, especially in the case of emotional problems and depressive symptoms (Moller-Leimkuhler, 2002, p. 1). One explanation for this discrepancy may be that men and women perceive emotional distress differently (Leaf & Bruce, 1987). Another reason for this difference may be that women, indeed, have higher rates of mild psychiatric disorders than men (Kessler, Brown, & Broman, 1981). To wit, high femininity in males (expressive, communal traits) may be related to both depression and anxiety levels (Gianakos, 2000).

Yet another explanation may be that “women are more ready than men to translate non-specific feelings of psychiatric symptoms into conscious problem recognition” (Kessler et al., 1981, p. 60). Further, men may be less likely than women to interpret depressive symptoms as signals of an emotional problem (Kessler et al., 1981). In this regard, women are more likely than men to recognize that they have a psychiatric problem and to discuss this problem with family, friends, and professionals (Horwitz, 1977). However, because men often fail to recognize the presence of a psychiatric

problem, they are usually coerced by family members or co-workers into treatment (Horwitz, 1977), no less to be committed against their will for treatment (Kessler et al., 1981). Men are also more likely than women to deny that a psychological problem actually exists (Rogler & Cortes, 1993) and (see below) to turn to alcohol or drugs as a defense (Gianakos, 2002). Each of these factors may contribute to the increasing stigma associated with seeking help from mental health professionals.

Many people seek help for psychological problems at the primary care level; only a small percentage actually enter the specialized mental health care system (Tijhuis et al, 1990). A substantial portion of mental health treatment is provided by general medical practitioners where women outnumber men seeking help for mental or emotional problems. (Luoma et al, 2002). Males are more likely to present psychological problems at a health facility with a non-psychological image (Nagelberg, et al, 1983, p. 528). However, males presenting to a primary care facility or practitioner may not be sufficiently recognized as depressed when they are (Rutz et al., 1997). Verbrugge (1984) examined physician treatment of mentally distressed men and women. Results indicated that men are more likely to have general examinations, medical counseling, or no service at all in comparison to women. Further, when men reported emotional problems, physicians were more likely to give them formal diagnoses of mental disorders and to label them as mentally ill (cf., Kessler et al., 1981).

O'Neil et al (1984) found that the severity of depression was the single most important factor in predicting help-seeking and that there were three help-seeking steps utilized. First, individuals turned to family and friends for help. When family and friends were unavailable or inadequate, individuals sought help from family physicians,

advisors, and clergymen. As a last resort, if these sources of help were unsatisfactory, individuals turned to specialist helpers such as psychiatrists or psychiatric clinics.

Summarizing this line of research, men may have difficulty recognizing the presence of emotional problems, thus limit their seeking help for such problems. Second, men tend to receive more mental disorder diagnoses when they do present with emotional problems, to be labelled as mentally ill and to be involuntarily committed for treatment. These consequences may serve to perpetuate the stigma associated with mental illness, which in turn may deter men from help-seeking. Third, both men and women tend to seek help from primary care physicians for emotional problems. Since these physicians may not be as sufficiently trained in diagnosing mental, misdiagnoses may occur. In addition, men may not seek help beyond the general medical sector, or may seek help from mental health professionals only as a last resort. Therefore, they may fail to have the opportunity to experience the benefits of the mental health treatment, or may only present to mental health professionals once problems have increased to an intolerable level of severity and/or are so chronic as to be more difficult to treat. Finally, when seeking help from general practitioners, men may receive less adequate services in comparison to women. This may serve to discourage men from help-seeking as interventions may be insufficient to help them with their problems.

Physical Health Problems

Research suggests that “women are more sensitive to subtle bodily cues than men,” which may account for “the higher rates of formal medical care utilization among women” (Kessler et al., 1981, p. 50). However, when men actually do seek help from

physicians, they often present with no complaints or general complaints about their health, hoping that they will be asked appropriate questions to uncover the underlying reasons for their visit (Tudiver & Talbot, 1999). Further, men usually need to have a tangible problem before seeking help from physicians (i.e., getting a physical for a special driver's license) (Tudiver & Talbot, 1999).

Substance Abuse

Men drink and abuse alcohol far more than do women (Blazina & Watkins, 1996). They also “prefer alcohol as a means of ‘self-care’ or to stabilize their identity in a manner which is socially compatible with their gender role” (Moller-Leimkuhler, 2002, p. 6). Gianakos (2002) found that men are more likely than women to cope with stress by using alcohol. Further, Simpson and Tucker (2002) suggest that “self-recognition of drinking problems usually occurs many years before initial help-seeking and is associated with the emergence of near daily, abusive drinking” (p. 660). In other words, men tend to recognize the onset of substance abuse problems, but delay seeking help for these problems until they become excessive.

One explanation for delay in help-seeking for substance abuse problems is that the characteristics of treatment programs are uninviting. Schober and Annis (1996) list these as: negative expectations about treatment efficacy, long waiting lists, failure to provide a consistent therapist, stringent abstinence requirements rather than treatment goals aimed at moderation, low morale and poor therapeutic commitment by staff, and placement of addiction services in a stigmatizing psychiatric setting (p. 87). Some features of Alcoholics Anonymous (AA) may serve to actually promote help-seeking. George and

Tucker (1996) found that AA's privacy, free cost, and spirituality, were considered incentives for its use. Timko et al (1993) found that problem drinkers who entered AA for treatment had less severe drinking problems than those who entered inpatient or residential treatment settings.

Certain characteristics of the help-seeker may also have an effect on seeking help for alcohol-related problems. Kaskutas et al (1997) observed that those who sought help tended to be those who had experienced three or more alcohol-related social consequences in their lifetime (i.e., problems at work, at home, or with friends). Blazina and Watkins (1996) showed that the success, power, and competition variable of gender-role conflict was associated with an increased report of alcohol usage, and the restrictive emotionality component of gender-role conflict was associated with more negative attitudes toward help-seeking.

Summarizing this research, it is clear that men, in particular, use alcohol as a means of coping with (or avoiding) their problems, rather than actively seeking help to resolve their problems. Consequently, they actually may add to their problems (by adding substance abuse as yet another) and/or exacerbate existing problems, such as depression. Second, as with other problems, men typically delay seeking help for substance abuse problems until the severity of their abuse has increased to the point where it interferes with everyday life. Finally, certain aspects of gender-role conflict increase the likelihood of substance abuse, while other components increase negative attitudes toward help-seeking. Therefore, men who are gender-role conflicted may be more at-risk for substance abuse problems, and, also, less likely to seek help for these problems.

HIV/AIDS

Hays et al. (1990) studied the relationship between help-seeking and psychological distress among gay men with various HIV diagnoses. Their results indicated the following: (1) AIDS-diagnosed and HIV-positive men experienced the most AIDS-related worry and were the most likely to seek help; (2) a large percentage of AIDS-diagnosed men sought help from a variety of sources (i.e., family, friends, professionals); and (3) regardless of men's HIV status, peers were perceived as the most helpful source of support, while family members were perceived as the least helpful source of support.

Saunders and Burgoyne (2001) found that the majority of HIV/AIDS outpatients requested help from professional services. Further, they found that those who requested practical support (i.e., housing, financial concerns, and access to medications) reported significantly fewer friends, less understanding, encouragement, advice, and guidance from others). Those who requested emotional support were more likely to report significantly lower positive social interaction (i.e., availability of others for enjoyable activities) than those who did not request such support.

Once again, we see that peers are considered to be the greatest source of support for homosexual men, regardless of their HIV status. Only, when support from friends is absent or considered inadequate, are these men more likely to seek help from professional support services for HIV/AIDS related issues.

Cancer

Research has shown that more men than women get cancer, die from cancer, and adapt less well than women after a cancer diagnosis (Nicholas, 2000, p. 27). It has been suggested that this disproportionate incidence of cancer in men may be attributable to certain risk behaviors related to gender-role socialization (Nicholas, 2000). For example, excessive alcohol and tobacco use are greater in men than in women, and “an estimated 75% of all oral cancers and cancers of the pharynx are caused by smoking and alcohol use” (Nicholas, 2000, p. 28).

Nicholas (2000) suggests that men may be more likely than women to ignore cancer symptoms and, as a result, delay seeking appropriate medical care, attributing this delay in help-seeking to a lack of basic health knowledge and perceived invulnerability to disease. It is not known, however, whether increased information/awareness will actually promote increased help-seeking behaviour among men.

Suicidality

Contact with professionals does occur prior to a suicidal act (Barnes et al, 2001; Luoma et al, 2002). Barnes et al. (2001) found that when adolescents and young adults (ages 13-34) who had made a nearly lethal suicide attempt sought help, they were likely to have discussed suicide with consultants, especially professional consultants. However, in general, suicidal adolescents and young adults were less likely to seek help than those who were not suicidal. Further, friends and family were the most frequently reported contacts regarding health and emotional problems for the majority of participants in the study. These researchers did not report gender differences among their suicidal subjects.

Luoma et al. (2002) reviewed a large number of published studies and reported that three out of four suicide completers had contact with primary care professionals within a year of their suicide, and 45% had contact within a month. Approximately one-third of suicide completers had contact with mental health professionals within a year of their suicide, and about one in five had contact within a month. Significant gender differences were found for mental health services contacts within one month (females: 36% vs. males: 18%) within one year (58% vs. 35%), and with regard to lifetime contact (78% vs. 47%). Similar findings have been reported from Australia (Pirkis et al, 2001) and Finland (Suominen et al, 2002).

This research reinforces the premise for this review, i.e., that only about one in five males who complete suicide have contact with a mental health professional shortly before their death. Overall, contact with primary care professionals is more frequent than is contact with mental health care professionals. Therefore, interventions with primary care physicians regarding the risk factors associated with suicide, specifically emphasizing at-risk behaviors and attitudes, is called for. Also, in general, friends and family are frequently consulted about emotional and health problems. Thus, interventions should also focus on including families and friends as allies in suicide prevention efforts, including awareness of professional resources available to help their loved ones.

Other Factors Promoting Help-seeking among Men

Three additional factors appear to promote help-seeking among men. First is the role of women. Tudiver and Talbot (1999) found that, when men do seek help, it is

usually from a female partner. These women tend to “listen to their health concerns and urge them to seek medical help” (p. 49). Helping women effect referrals for professional help may be an important link in the chain toward male help-seeking/help-receiving. A recent study (Mishara et al, 2005) supports this hypothesis. These researchers found that helping third party callers to a suicide prevention center (typically women) had significant impact on the suicidality of high risk men.

Further, Zeldow and Greenberg (1979) found that men who have more liberal attitudes toward women, with regard to their rights and roles in society, had more positive attitudes toward help-seeking. Nadler et al (1984) found that men were more willing to seek help when the helper was a female than when the helper was another male. They attributed this finding to the belief that men may perceive seeking and receiving help from a woman as “less self-threatening” than seeking and receiving help from a man (p. 336). Further support for this observation comes from evidence that males, indeed, are more pejorative in their labelling of males with mental health problems and implied suicidality than they are of females with the same presenting symptoms (Berman, 1978).

Other research suggests that the perceived severity of a psychological problem affects help-seeking. Calhoun et al (1972) found that people who perceived their psychological problems as less severe tended to have more positive attitudes toward help-seeking. In addition, Calhoun and Selby (1974) found that the less distress people experienced, the more favorable their attitudes were toward help-seeking. Biddle (2002) reported that suicidal males had a higher threshold of severity than did females before they sought help.

Finally, research suggests that internal working models of close relationships affect help-seeking. Internal working models are shaped by “the quality of one’s early experiences with care-giving figures - particularly around themes of separation, distress, and reunion” (Lopez et al., 1998, p. 79). Lopez et al (1998) found that people who had positive self models (basic perceptions of one’s own worth, competence, and lovability) reported fewer problems than people with negative self models. They also found that people who had low levels of problems and positive models of others (core expectations regarding the goodness, trustworthiness, and dependability of important others in one’s social world) were most likely to seek help. These results indicate that positive models of the self and others may decrease the number of problems experienced, as well as increase help-seeking when problems are encountered. A variant on this finding is that identification with positive role models, e.g., celebrities, may be a useful technique to utilize in effecting increased help-seeking behavior.

Discussion

Given the relative lack of help-seeking among at-risk males, and the foregoing observations to explain this, it is not surprising that existing models of suicide prevention tend to have greater demonstrated effectiveness with women than with men. For example, crisis intervention services have been found most helpful to young adult women, who are the most frequent callers (Miller et al, 1984).

It is tempting to argue that one way to increase help-seeking behavior among men would be to help men to become less constrained by gender-role expectations. Psychosocial treatment models of help-seeking have been developed to focus on

traditionally masculine ways of relating. For example, psycho-educational workshops and courses on fathering and the process of masculine gender-role socialization might be more universally offered. Alternatively, person-situation models of help-seeking have been developed. In this model, the person side involves the “endorsement of particular beliefs about what it means to be a man” and the situation side involves “potential help-seeking contexts” (Addis & Mahalik, 2003). For example, interventions that emphasize “self-help, technical competence, and an achievement orientation” are favored (Addis & Mahalik, 2003).

The research presented in this paper strongly supports this latter emphasis. As outlined in Table 1, we recommend the development of public health interventions that promote help-seeking among men, not by attempting to make men more like women, but, rather, by structuring media-based messages in content and delivery that speak to men “where they are at”

[Insert Table 1 about Here]

First, public information campaigns might emphasize the social benefits of help-seeking to males. Males may respond better to messaging that emphasizes help-seeking as evidence of courage (“It takes a man to...”), as an act of independence (“Most men suffer in silence...”), as potentially improving performance, making oneself even more competent, and increasing a personal sense of, and other-perceived, control. Each of these messages would clearly need to be focus group tested to best frame their presentation.

Second, males may respond better to public health messaging that attaches increased self-care behavior to their responsibilities as provider and care-taker, for

example, of and for their children. This approach acknowledges males' needs for reciprocity, i.e., to seek and receive help translates into being able to give to those more vulnerable, and the preservation of status.

Third, public health messaging needs to frame help-receiving as cognitively, versus emotionally, focused. Thus help-seeking is meant to achieve better problem-solving. Redefining and re-conceptualizing symptoms and mental disorders into terms that are more acceptable and less stigmatizing to males should help. These messages are consistent with what those given in cognitive-behavioral (CBT) therapeutic approaches, for which we have evidence for treatment effectiveness with suicidal patients (cf., Rudd, Joiner, & Rahab, 2001). Moreover, CBT models tend to be shorter term than other therapies and, most importantly, emphasize collaboration between therapist and patient, a significant message that counteracts the more dependency-based, doctor-patient relationship in more traditional talk- and feeling-based therapies.

Fourth, framing messages with differential loci of control may be more acceptable to men. Attributions for problems should be externally focused, i.e., not perceived as evidence of personal weakness or fault; while attributions for problem-solving should be internally focused, e.g., "you can make a difference..."

Fifth, information is preferred over confrontation. Moreover, increasing awareness that aids in *early* problem definition is important. For example, linking symptoms (e.g., insomnia) to proximal complications (e.g., poorer concentration and work performance) no less yet more distal and tragic outcomes (e.g., despair and suicide) may help in this regard.

Consideration needs to be given to the delivery of public health messages designed to increase male help-seeking.

First, using male identification figures, e.g., sports celebrities, to deliver personalized help-seeking messages normalizes the behavior as masculine. This approach has been successful in the marketing of medications for erectile dysfunction (Addis & Mihalik, 2003).

Second, marketing messages to family, especially female loved ones, may further influence males to seek help as a care-taking (of others) behavior. Similarly, sensitively depicting the effects of male psychological dysfunction on children, as vulnerable victims of their father's problems, may motivate fathers to seek collaborative help. This is difficult terrain, as one has to be careful not to stimulate suicidogenic thinking, such as "they'll be better off without me." Messages targeted to the gay community would most effectively be directed toward peers; and culturally specific targets, e.g., religious leaders, might be the focus for people of color.

Third, public health strategies that rely on message delivery pathways (contextual settings) more likely to reach males should be used. These include sporting events, public men's rooms, the Internet, and primary care physicians (PCPs). Not only are PCPs in better position to deliver help-seeking messages, they are in position to normalize the behavior by referencing other male patients who have benefited from treatment interventions.

It is essential, in this regard, to bolster the assessment and treatment skills of PCPs, specifically brief and effective interviewing approaches that maximize their ability to deflect denial and better assess the presence of suicidal risk (cf., Shea, 1999). PCPs, as

well, need to be better trained to specific information regarding signs of suicide risk and appropriate referral making skills in case of assessed risk.

Other potential interventionists might also be targeted for information and training. With particular focus on the depressed male who has developed a drinking problem, thus is at increased risk for suicide, bartenders could be targeted to be trained gate-keepers (Brooks, 1976). Similarly, divorce and bankruptcy attorneys might be appropriate gatekeepers to mental health services if sufficiently trained.

Lastly, it is imperative to develop pathways of help-seeking and receiving that do not challenge a man's need to maintain an image of functional performance. Innovative interventions designed to reach men on the job, e.g., e-mail systems of cognitive-based treatments (e.g., Langdon, 2002), or increased weekend service availability models might be considered and pilot tested.

None of the above proposals have yet been sufficiently elaborated or developed into interventions that might better reach and motivate males to seek help. To accomplish this, it will be necessary to create collaborations among the suicidology, public health, mental health, marketing and media communities to accomplish and evaluate a significant demonstration project to increase male help-seeking and reduce suicidality among men. This is one instance where affirmative action is demanded for the more vulnerable majority.

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Table 1
 Research-based Recommendations for Public Health Interventions
 to Increase Male Help-Seeking Behavior

<p>Emphasize Social Benefits: Help-seeking is</p> <ul style="list-style-type: none"> • Courageous • Independent • Performance/Competency Enhancing • Taking Control • Responsible to/Care-taking of Dependents • Reciprocal • Cognitively-based • Short-term • Collaborative • Problem-solving
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Emphasize Gender-Appropriate Delivery Systems

- Masculine Identification Figures
- Females, Peers
- Male Contextual Settings
- Trained PCPs, Bartenders...
- Respectful of Perceived Need to Work

**American
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AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. For membership information, please contact:

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If you or someone you know is suicidal, please contact a mental health professional or call 1-800-273-TALK (8255).