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Injury, Interiority, and Isolation in Men's Suicidality

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Abstract

Men's high suicide rates have been linked to individual risk factors including history of being abused as a child, single marital status, and financial difficulties. While it has also been suggested that the normative influences of hegemonic masculinities are implicated in men's suicide, the gendered experiences of male suicidality are poorly understood. In the current photovoice study, 20 men who previously had suicidal thoughts, plans, and/or attempts were interviewed as a means to better understanding the connections between masculinities and their experiences of suicidality. The study findings revealed injury, interiority, and isolation as interconnected themes characterizing men's suicidality. Injury comprised an array of childhood and/or cumulative traumas that fueled men's ruminating thoughts inhibiting recovery and limiting hopes for improved life quality. In attempting to blunt these traumas, many men described self-injuring through the overuse of alcohol and other drugs. The interiority theme revealed how suicidal thoughts can fuel hopelessness amid summonsing remedies from within. The challenges to self-manage, especially when experiencing muddled thinking and negative thought were evident, and led some participants to summons exterior resources to counter suicidality. Isolation included separateness from others, and was linked to abandonment issues and not having a job and/or partner. Self-isolating also featured as a protection strategy to avoid troubling others and/or reducing exposure to additional noxious stimuli. The study findings suggest multiple intervention points and strategies, the majority of which are premised on promoting men's social connectedness. The destigmatizing value of photovoice methods is also discussed.

Keywords

men's suicide, masculinity, men's mental illness, photovoice

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Introduction

High male suicide rates continue to draw commentaries regarding individual-level risk factors including a history of being abused as a child (Easton, Renner, & O'Leary, 2013), single marital status (Yip, Yousuf, Chan, Yung, & Wu, 2015), and job loss and financial difficulties (Coope et al., 2015). Despite these insights and long-standing epidemiological evidence that suicide is a significant men's health issue, remarkably, there has been little targeted research to inform men's suicide prevention and/or intervention strategies (Beaton & Forster, 2012). This relates to the paucity of research capturing the lived experience of suicidality, perpetuated by the stigma surrounding male suicide (Oliffe et al., 2016). The current article shares the findings drawn from men who previously had suicidal thoughts, plans, and/or attempts as a means to better understand the connections between masculinities and their experiences of suicidality.

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Masculinities and Men's Suicide

The issue of male suicide has drawn some important work from gender researchers. In particular, social constructionist gender frameworks have been used to theorize connections between normative masculinities (Connell, 1995), including the forms of masculine "capital" therein, and men's suicide. Applying Connell's (1995) frame, hegemonic masculinities and Western men's suicidality have been linked to wielding power and dominance over women and some men through actions, and discourses that imbue aggression, competitiveness, self-reliance, and stoicism. The diverse performativity's taken up by men in response to these hegemonic masculinities reveals a plurality of masculinities and configurations of practice. Within the plurality of masculinities, for example, suicide risk in gay and bisexual men (Ferlatte, Dulai, Hottes, Trussler, & Marchand, 2015; Hottes, Bogart, Rhodes, Brennan, & Gesink, 2016), military men (Braswell & Kushner, 2012), and men in rural or remote residence (Alston, 2012) have been highlighted. Despite the plurality of identities, expressions and practices within these communities—normative, reductive constructs still have considerable and, at times, detrimental impacts. These works suggest that specific masculine cultures and communities of practice can draw men toward self-harm (Creighton & Oliffe, 2010). For example, social integration into the military's fatalistic masculinity has been cited as contributing to the high rates of suicide among military men (Braswell & Kushner, 2012).

Alongside research disaggregating masculine cultures by sexual identity, occupation, and place, country-specific studies report how masculine ideals can work for and against men at risk of suicide (Cleary, 2012; Emslie, Ridge, Ziebland, & Hunt, 2006; Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012). Within this context, characteristics of hegemonic, heteronormative masculinities—including concealing distress and alcohol overuse—were explained as taking young Irish men toward suicide (Cleary, 2012). Oliffe et al. (2012) reported similar results among middle-aged Canadian men but suggested that participant's alignments to provider and protector roles (reflective of gender-specific and normative masculine qualities) had the potential to link them to professional care and effective self-management of suicidal thoughts. Emslie et al. (2006) secondary analysis of U.K.-based men who experienced depression also reported that connections to family were a deterrent to participant's acting on suicidal thoughts.

The aforementioned insights have been important to advancing understandings about masculinities and men's suicide. Despite the profound social impact of men's suicide, the inner workings and underpinnings of men's suicidality are often somewhat estranged from the epidemiological data, and without such knowledge researchers, clinicians and the public are challenged to prevent or intervene toward reducing male suicide. The current study is deliberately placed within a broader sociological context based on a belief that men's suicide can be best understood, and potentially prevented, if the problem and solutions are understood as a gendered social phenomenon.

Method

Sample

A total of 20 men, aged 20 to 62 years (mean = 42), with a history of suicidality participated in the study. Most participants were born in Canada ($N = 17$; 85%), heterosexual ($N = 15$; 75%), single ($N = 15$; 75%), unemployed ($N = 11$; 55%) and resided in Vancouver, British Columbia ($N = 19$; 95%). Participants self-identified their ethnicity as Canadian ($N = 14$; 70%), Aboriginal ($N = 1$; 5%), East Asian ($N = 1$; 5%), Lebanese ($N = 1$; 5%), Chinese ($N = 1$; 5%), Mixed ($N = 1$; 5%), and Asian ($N = 1$; 5%). Participants had previously experienced suicidal thoughts ($N = 20$; 100%), planned their suicide ($N = 15$; 75%), and/or attempted suicide ($N = 9$; 45%). Most participants had received professional help for their suicidality ($N = 14$; 70%), including seven of the nine participants who had attempted suicide. Thirteen men had been formally diagnosed with mental illness(es) including depression ($N = 8$; 40%), bipolar disorder ($N = 4$; 20%), personality disorders ($N = 4$; 20%), and anxiety ($N = 3$; 15%; see Table 1 for additional details).

Data Collection

Following University ethics approval, recruitment flyers were posted in the Greater Vancouver area at community centers, public libraries, and markets. Online advertisements were also shared through social media sites Craigslist and Kijiji. Potential participants who contacted the project manager by telephone or e-mail were screened for eligibility. Men who had previously experienced suicidal thoughts, plans, and/or attempts and were English speaking, 19 years and older, and resided in Canada met the inclusion criteria. Eligible men were invited to an initial meeting with the project manager to discuss the study goals and written consent form. Participants were told about the photovoice assignment and subsequent photo-elicitation interview, and potential risks of participation were discussed while providing assurances that they could withdraw at any time without consequence. After providing consent, participants completed a demographic survey, and were offered a new digital camera (which they could keep as an honorarium) to take photographs to illustrate their experiences of suicidality and perspectives

Table 1. Aggregated Sample Demographics.

Demographics, *N* = 20	*N* (%)
Age (years; range = 20-62; mean = 42)	
20-29	6 (30)
30-39	2 (10)
40-49	6 (30)
50-59	4 (20)
60-69	2 (10)
Marital status	
Single	15 (75)
Married/common law	5 (25)
Sexual orientation	
Heterosexual	15 (75)
Gay	3 (15)
Bisexual	2 (10)
Employment status	
Unemployed	11 (55)
Employed	7 (35)
Student	1 (5)
Retired	1 (5)
Living status	
Alone	7 (35)
Spouse/partner/family member	5 (25)
Roommate(s)	5 (25)
Other family member	3 (15)
Highest education	
High school	5 (25)
College	4 (20)
University, undergraduate	10 (50)
University, graduate	1 (5)
Birthplace (country)	
Canada	17 (85)
China	1 (5)
USA	1 (5)
Lebanon	1 (5)
Age (years): First suicidal thoughts	
0-9	2 (10)
10-19	10 (50)
20-29	5 (25)
30-39	3 (15)
Planned suicide	15 (75)
Attempted suicide	9 (45)
Mental illness diagnosis	13 (65)
Specific mental illness(es)	
Anxiety	3 (15)
Depression	8 (40)
Bipolar disorder	4 (20)
Personality disorder	4 (20)
Schizophrenia	1 (5)
Asperger's syndrome	1 (5)
Previous or current treatment(s)	
Yes	14 (70)
Health care provider of the treatment(s)	
Family physician	6 (30)
Psychiatrist	9 (45)
Psychologist	3 (15)
Counsellor	1 (5)
Treatment type(s)	
Medication(s)	10 (50)
Individual counselling/ psychotherapy	12 (60)
Group therapy	5 (25)

about male suicide. Participants who preferred to use their own digital camera were offered a $100 honorarium (the approximate value of the new digital camera). Many participants asked questions about what kinds of photographs to take. The men were assured that all photographs expressing their experiences and perspectives were welcomed, but if they included other people in their photographs they would need to have the person's signed consent (a form was provided to collect this authorization). Participants completed the photovoice assignment over a 2-week period, and shortly thereafter an individual, semistructured photo-elicitation interview was completed. Digitally recorded interviews took place from 2014 through 2016 at a university office, and lasted between 40 and 240 minutes. The interviews were conducted by two male and two female masters and/or PhD prepared, experienced qualitative researchers. Participants were advised that some details discussed might trigger mental health issues, and that the interviewer would offer to cease the interview if any distress was observed. Participants were also provided a printed sheet of local mental health resources prior to the interview, and encouraged to access those services if issues arose during or after the interview.

Grounded in the interpretive descriptive traditions of qualitative research (Thorne, 2016), photo-elicitation techniques were used (Oliffe & Bottorff, 2007). An interview guide was used to direct conversations early on, and this included open-ended questions and prompts including, "Tell me about yourself, your family and cultural background," and "What feelings and expressions accompanied your suicidal thoughts?" Although an interview guide was used, the participants' photographs were the focal point wherein prompts including "Can you say a little more about that?" and "What does X represent in this photograph?" were used to elaborate on participant's experiences and perspectives. A second honorarium of $100 was provided to participants at the end of the interview to acknowledge their time and contribution. The

Table 2. Participant Characteristics.

Pseudonym	Age (years)	Sexuality	Employment	Relational status	Self-identified ethnicity
Jimmy	36	Heterosexual	Unemployed	Married	Aboriginal
Raj	31	Heterosexual	Unemployed	Single	East Asian
Omar	53	Bisexual	Unemployed	Single	Canadian
Russell	48	Heterosexual	Unemployed	Single	Canadian
Malik	46	Heterosexual	Unemployed	Single	Lebanese
Eric	28	Heterosexual	Unemployed	Single	Chinese
Ricky	60	Gay	Unemployed	Single	Canadian
Graham	50	Heterosexual	Unemployed	Married	Canadian
Owen	26	Heterosexual	University student	Single	Canadian
Ronnie	40	Heterosexual	E-commerce	Single	Chinese
Pete	49	Heterosexual	Tower technician	Single	Canadian
Sam	58	Heterosexual	Hospitality	Single	Canadian
Evan	27	Heterosexual	Project manager	Single	Mixed
Von	23	Heterosexual	Barista	Married	Canadian
Brett	59	Heterosexual	Retired	Married	Canadian
Wes	20	Heterosexual	Automotive mechanist	Single	Canadian
Danny	62	Heterosexual	Unemployed	Single	Canadian
Virgil	49	Bisexual	Unemployed	Married	Canadian
Michael	25	Gay	Unemployed	Single	Asian
Derek	45	Gay	Visual artist	Single	Canadian

digitally recorded interviews were transcribed verbatim, cleaned of any potentially identifying information and checked for accuracy. The participant-produced photographs were inserted to the word version interview transcripts alongside the corresponding narratives.

Data Analysis

Data analysis were guided by constant comparison methods (Strauss & Corbin, 1998) wherein the first two authors read the 20 hard copy transcripts marking up key excerpts and jotting notes in the margins to signal and share interpretations and potential codes for organizing the data. In monthly meetings over 12 months, the data were discussed and interpretations compared to distil what prevailed across the interviews, and to refine the research question addressed in the current article. Seven broad codes were initially developed: trauma, social isolation, depressive symptoms, internalizing, remedy, health care, and messages to other men. In terms of weightings, data fitting with the trauma, social isolation, and internalizing codes were most consistently represented within and across all the interviews and became the focus of the analysis. Guided by the research question, *What are the connections between masculinities and men's experiences of suicidality*? data allocated to the three aforementioned codes (trauma, social isolation, and internalizing) were reread to further develop the analyses and thematic labels. Five coauthors also independently reviewed and coded one interview transcript each, and the newly coded data were discussed among the seven author team and subsequently integrated to the previously coded transcripts. The authors worked with the drafted themes to develop the findings section, and through the writing up of the current article, consensus was reached about thematic labels, illustrative quotes, and representative photographs. The three inductively derived themes—(a) injury, (b) interiority, and (c) isolation—are presented separately though elements of each featured within and across the participant's interviews. Illustrative quotes were connected to participant demographics and researcher allocated pseudonyms (see Table 2), while a photograph and the accompanying participant narrative were shared for each of the three themes.

Findings

Injury(s)

The men's injuries emerged from psychological traumas wherein hurt and harm had caused damage which was implicated in the participant's suicidality. In terms of life course, many men reflected on negative childhood experiences and events suggesting significant injuries had occurred in their formative years. Family issues were described as invoking challenges that many men were ill

Figure 1. Abandoned (Submitted by Wes).

prepared to cope with and/or fully recover from. Malik recalled how, as a child, his family life was characterized by unhappiness and abuse in foregrounding his adult struggles with suicidality:

> I was a product of a broken home because my family was always fighting . . . infidelity and all that stuff. They [parents] did separate but I felt it was really traumatic on the kids including me just to see each other, hate each other and attack each other. It was really distressing.

Similarly, Wes described his childhood as marked by a succession of challenges and losses beginning with his parents' divorce wherein neither his mother nor father expressed an interest in having him live with them. He recalled their bitter divorce, and sense of abandonment, as his parents' conflict centered on their financial settlement. Wes also spoke of high school friends who drifted away from him during this upheaval amid losing his first girl friend who, despite his best efforts, left him for another man. While his ex-girlfriend contacted him "when she needed something," Wes conceded that she had little genuine interest in rekindling their relationship. Wes talked about the condemned building featured in Figure 1, offering this visual as a representation of the hopelessness that flowed through and from these cumulative injuries, which collectively lingered unresolved to limit his future prospects and eventually shaped his suicidality.

> I think it's kind of what happened to me—for a while it kind of feels like, yeah, "you're useful, you're doing good," and then its just—eventually you might just end up being abandoned, you're going to be abandoned.

Central to Malik and Wes, and many other participants, were injuries that had occurred early on but carried significant weight into adulthood, fundamentally shaping their sense of self and self-worth. As Graham lamented "My childhood plays an enormous role in where I am in my adult life now" in disclosing "I have a history of abuse in my life, as a child." Graham elaborated that he had tried to suppress the memory of those traumatizing events but eventually, in his 30s, the child abuse he experienced manifested as suicidality:

> I literally got out of bed one day, and was hit with a hammer, uh, around abuse that I had suffered over a 2-year period when I was 8 years old, from 8-10. A series of events that I had very neatly packaged up into a box and I'd put it up on the back shelf in my brain, and I bumped my head one day and the box fell off, and all the contents just spilled out.

While the men detailed diverse injuries across the life course, most seemed to ruminate on these negative events in predicting recurrence and/or reinjury as a fate accompli. For example, Russell described how a troubled relationship with his parents while growing up had led him to sabotage a series of intimate relationships including his marriage, "I just sort of made them hate me until they'd break up with me." Many of the men belabored such events linking injuries past to their current challenges and suicidality. As Eric confirmed, childhood traumas had a lasting impact:

> I really grew up alone, so now I'm a really emotional person, like there's ups and downs every day.

The men's accounts of their injuries signaled them as straying from masculine ideals associated with strength of mind, emotional restraint, and resilience. Yet they often struggled to process and deal with them within the context of these very idealized conceptions. Depicting their ongoing struggles as losing battles, participants' failure to disregard or recover from their injuries also constituted a site of failing to embody masculine ideals around control and self-reliance. What emerged was a double bind of normative masculine constructs—an internalized failure to live up to an ideal, amid being constrained by the desire to perform these very ideals. Only a few participants, including Ricky, explicitly resisted masculine ideals scripting men to be stoic in denying injury and feelings, poignantly cautioning that "conditioning us [men] away from our emotional reality is going to make it harder when your emotional reality is what's ripping you apart."

Prevalent also were men's accounts of having overused alcohol and other drugs to distance themselves from injuries and/or blunt what they felt in relation to these troubling experiences. Raj traced his overuse of alcohol and drugs to his childhood traumas in asserting, "When a

kid feels unwanted he eventually turns to something, it's a regulator right, like because I learned that I can't count on people." Raj explained that he shared alcohol with his family (the majority of whom he suggested also overused alcohol) because it garnered a faux sense of being wanted. He quipped, "I know that if I have beer I can count on the feeling that they are happy to see the beer at least." Malik also emphasized that his drug addiction had failed to garner the love and support he craved from his family, suggesting "Most families if they have strong parents, and their son's using drugs, they would try to get them help." Central to many men's overuse of alcohol and other drugs were their unresolved injuries. Indeed, in cases such as those of Raj and Malik, substance overuse likely exacerbated some of the very injuries they were trying to escape and/or blunt. Substance overuse was also normed as a cultural practice which men routinely engaged to demonstrate their masculinity, as previously reported by Oliffe, Galdas, Han, and Kelly (2013).

Many participants also suggested that their substance overuse was purposeful in self-injuring, and in some cases, men indicated that these practices flowed from their ambivalence for living. Russell suggested,

> I was drinking myself to a slow death, but it wasn't like suicide, it was like "okay, well, gee maybe if I drink enough I'll get sick enough that that'll be it," it'll be terminal something or other and that'll be that.

Graham described his alcohol and drug overuse as "A fog, it was a drug-induced haze of self-abuse . . . a torturous time, it was masochistic." Similar self-harm and ambivalence for living was described by Malik, who labeled his actions as "chronic suicide":

> I would sometimes get so high I'd want to end it. But I wouldn't want to kill myself, I was too afraid to kill myself. So, I'd just do a lot of drugs and then I'm in a bathroom, in a heavy bar in a bathroom like passed out. It's addiction and at the same time it's a feeling of hopelessness, like low self-esteem that I can't get out of this so I'll just stay in this behavior.

While men's alcohol and drug use have strong connections to hegemonic masculinity (De Visser, & Smith, 2007), the current study findings revealed participant's substance overuse as tied to significant (re)injury. These normative constructs provided a form of entrapment whereby repression became the only "masculine act" available in a context where expression was viewed or read as weakness. Jimmy related the negative consequences on his mental illness and family:

> I just kind of blew through all my money . . . I was just wobbly and paranoid so it [alcohol and drugs] wasn't a help. It was just terrible . . . I just kind of threw a lot of time away when I didn't have that time, and I kind of lost a lot of time with my son.

Jimmy's retrospection detailed how his substance overuse exacerbated his mental illness further distorting his perceptions. Similarly, Pete, a man who struggled with heroin addiction affirmed, "You don't really see the whole picture when you're depressed and have suicidal thoughts . . . you're not really seeing what you're looking at."

In summary, participants' injuries most often flowed from their early years and external triggers, and recursively injury, mental illness, and substance overuse entwined to prolong and heighten men's pain and suicidality.

Interiority

The interiority (i.e., inner experiences) of the participants' suicidality was ever present in their photographs and interviews. In the context of suicidal ideation, for example, a range of thought patterns were shared by the men when describing their experiences. Ricky detailed the hopelessness that flowed from his depression—the profoundness of which led him to consider suicide as a pain-ending strategy:

> Mostly the experience of that intense despair that I would feel suicidal is interior . . . it's not the triggers even, it's the inner experience of feeling trapped inside the despair . . . like it's never going to go away. It's always going to be like this, so that's the most intense. The worst pain is, you just don't think it will ever stop . . . and you don't know what to do to make it stop.

Evident in this, and many narratives was how suicidality could render men fatigued, without the capacity to quell or bear the accompanying pain. So deeply felt was the anguish, Ricky suggested that "When you're really lost—almost no words will help" conceding "though people on the outside try to do the best they can." The inside–outside distinction confirmed the interiority of his experience, and framed assertions that when in crisis, Ricky could not be reached or helped by external sources.

Unfortunately, outside pressures could also add to the burden of men's interiority, in gender-specific ways. Ricky suggested that, "If men don't have a way to make it in the world, they don't exist, they're nothing, they don't matter. And so if you don't matter, it doesn't matter whether you're here or not." Similarly, Malik explained that his lack of masculine capital rendered him inconsequential:

> I was inadequate in some areas that I'm supposed to be, you know, a rich guy with a beautiful woman. And if I don't

become that I'm going to feel unworthy, depressed, a loser, and that can lead me to feel depressed and maybe you know, take my life.

These examples revealed how the qualities held up as forms of capital or value for men, and men's lack of resources for securing those markers, served to marginalize and subordinate them within masculine hierarchies. Men's broader "biographical disruption" was also evident wherein the partial self or lack of a sense of social credibility prevailed to signal a degraded masculine self within such narratives. Internalizing and cogitating on their deficits, and lacking the symbolic and material resources to address perceived shortcomings, some men began to question the value of their lives in more fully considering suicide. In terms of the dialectic of agency and structure, the men's negative thoughts and self-doubts were magnified by certain spheres of the proper masculine—the normative, performative man—leaving the potential for external help, which resided within those very structures, completely obscured. Indeed, this is how marginalization often occurs, not necessarily (or often) through deliberate actions of others, but rather through the embedding of particular configurations of social practice within structures that then marks them, directly or indirectly, as inappropriate or inaccessible to these men (Robertson, Williams, & Oliffe, 2016).

The interiority of suicidality was also evident in the participants' stoicism and hypervigilance in avoiding self-disclosures about their mental illness and/or suicidality. Jimmy suggested that by observing his family he had learned early on that pain and suicidal thoughts should be kept to oneself:

> It's kind of embarrassing, because you don't want to feel weak, like, I have a lot of siblings and my parents are these really strong people who don't do it either. They don't tell you what they're really feeling, but you can see it . . . I kind of grew up with my parents not really releasing it, so that carried on to me.

Many men indicated the norming of silences round mental illness and suicidality, wherein stoicism, as an idealized masculine practice, was synonymous with strength. A by-product, however, was denial and resistance to help seeking for fear of being seen as weak. Indeed, the strength of silence juxtaposed the weakness in admitting mental illness, a dichotomy that further anchored suicidality as an internalized struggle for many men.

The interiority of suicidality also led to pressures to remedy the issue(s) from within. Talking about Figure 2, Raj detailed the challenges of finding the right combination of strategies to avoid suicide.

Figure 2. Locked (Submitted by Raj).

> This is a combination lock and it really shows a physical example of how you can get locked down, locked into your thoughts . . . thinking that there's never any light at the end of the tunnel or things aren't going to get better and then when that lock gets closed that's when you know you're very likely to commit suicide. When the lock is still open you can see that there's hope then you're less likely to commit suicide so . . . if you don't know the combination then you don't know how to get out of the depression and the suicide but if you know the combination you're able to unlock.

This trial and error self-management described by Raj was reported by many participants. Men focused on mustering remedy within, as a means to disarm, counter, and, ideally, conquer their suicidality. Ever vigilant attention was paid to ensuring they remained attentive and active in breaking the cycle of negative and dangerous suicidal thoughts. For many men, these inner struggles demanded strength, and placating suicidal thoughts and plans were framed as affording some participants much valued control over their outcomes. Eric described how quelling his intermittent impulses for self-harm was "empowering because every second that you're not dead is you deciding that you want to live." Though claiming this control as reflecting Eric's willpower to live, a few participants, including Wes conceded "For me, it's almost like I—almost know it's going to be suicide." Herein the provisional nature of countering suicidality from within was evident in both Eric's and Wes's accounts. In addition, this need to exert control, prevalent within configurations of hegemonic masculinity, has been reported to have a potentially beneficial role in recovery from mental health concerns (Emslie et al., 2006); yet suicide has also been said to be the ultimate expression of hegemonic masculine control in situations where no other avenue seems open (Swami, Stanistreet, & Payne, 2008).

Men's efforts for self-managing from within faltered, and some participants shared details about previous suicide attempts. Decidedly close calls, the men's change of mind was central to aborting suicide plans and attempts. For example, Russell decided against jumping from a bridge because it would add to his mother's "shame, guilt and stigma" which flowed from "her middle son killing himself" a year earlier. Russell linked his change of mind to his desire to protect his mother, in predicting "it'd be just over a year later her baby boy [Russell], decides to do himself in. And I . . . thought, 'Boy, that would kill her.'" Omar described his rescue from a potentially fatal overdose on prescription pills in the 1980s when he was at college:

> I romanticized it, and I went down to the gardens full of pills to fall asleep and just perish, but I got hungry, with a stomach full of pills, so—yeah, "I'm going to die, I'll just go to the Pub and have one last burger, one last beer." And I bumped into a friend of mine—a classmate of mine and his girlfriend and they thought I was drunk, because I was sticking the chips in my forehead instead of my mouth! And they're laughing and I said to Denis [friend], "I ate 'em like Smarties." He said, "What—what Smarties," I said, "All the pills!" . . . I said, "I don't know if I want to die right now, I—I better go to the hospital." So, he's laughing his guts out, he took me to the hospital—woke up in intensive care.

Albeit last minute, a change of mind about wanting to end his life saw Omar relinquish his interiority in soliciting outside help. Russell summoned an external motivator (e.g., mother) in countering his internal impulses toward suicide. While the men's change of mind might be argued as rhetorical rationales used to support their decisions, these external protections (e.g., friends, family) were rallied at crisis points. Building on this, Wes shared his aspirations to break with masculine ideals that rendered him, and many men, silent:

> I think a lot of guys look at it as they've gotta have tough skin, that's how it's been for years, right? I'd rather be the guy who—you know—tells them straight up—"I'm not okay, I need help," and they can try and help me, otherwise if I keep it all inside, I might make that mistake where I can't come back, and once you're done, you're done for good.

The assertion saw Wes exchanging forms of masculine capital, previously described by De Visser, Smith, and McDonnell (2009), wherein he forwent the expected emotional repression by being a strong straight-talker. Breaking with the interiority of suicidality to source external help was, however, reliant on participants insight and orientation to garnering effectual help. This was time sensitive, as the interiority of men's suicidality also threatened to delay or mute the soliciting of help to the point where it might be too late.

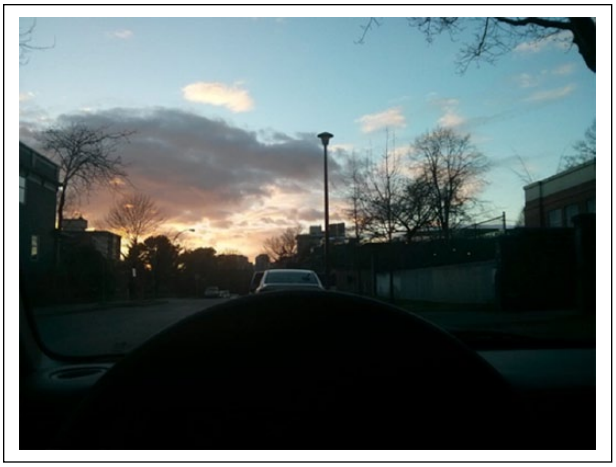

Figure 3. Faded Away (Submitted by Eric).

Isolation

Isolation included many participants describing an overarching separateness from others. Narratives detailed profound isolation alongside accounts depicting strategic efforts to protect others and/or themselves by self-isolating. Though the circumstances of the men's isolation varied, similar to research by Cleary (2012), being isolated ultimately heightened participants risk for suicide. Eric captioned Figure 3 "faded away" in describing the connectedness of his isolation and suicidality.

> It brings out really negative feelings when the sun sets, and I'm in my car and I'm about to go home . . . it feels like everyone's separated from the world and you're just all by yourself like an island. When I was feeling suicidal, that's my darkest time—when it gets dark, when it's light and starts getting dark and nobody's outside. It feels like you're the only person on earth . . . it's a feeling that's so unbearable that you just want to get rid of the feeling forever.

Eric spoke to his aloneness, and how those feelings enveloped with suicidality taking him closer to self-harm. He also recognized that his depression and suicidality, in and of themselves, could ostracize him further:

> When you think about someone who's the ideal guy, it's someone who's really sure about themselves, who really strives to be on the top in terms of a career in whatever they're pursuing, not someone who wants to give up on life . . . society views men who are depressed or who are suicidal as weak, they're seen as losers.

As Hearn (1992) suggests, public performances of masculinity draw scrutiny policing and critiquing men's behaviors, and Eric's contrast of idealized and subordinate masculinities highlighted how shame and societal

stigma can further marginalize men who visibly surrender to their challenges.

Though isolation was often linked to aloneness, some participants experienced isolation while appearing to be socially connected. Raj suggested, "I mean I know people, people know me. I have acquaintances, but I don't think I have any friends." Similarly, Owen recalled how at the height of his suicidal thoughts, "Everything felt like a façade, like, if I was out—having fun, I was putting on a smile for the show of others." Raj and Owen revealed how isolation could occur despite being in the company of others, providing a poignant counter example to stereotypical depictions of socially isolated men as actually being (rather than feeling) alone and lonely.

Other factors entangled men's mental illnesses contributing to their isolation. For example, unemployment, job insecurity, and workplace challenges fueled participants' struggles. Graham recounted the impact of losing a job he valued greatly when he was in his late 30s. He explained how he had confided in a colleague that he experienced depression, and subsequent to that disclosure the colleague was promoted, after which Graham reported directly to her. Following a disagreement with his new supervisor, "She accused me of being a potentially violent or dangerous person, and I was essentially forced to resign." Graham shared, "It's something that I literally think about daily, still 15 years later" in elaborating the torrent of negative outcomes that followed his job loss:

> Work is an integral defining component as to who I am or who I see myself as . . . I relate my own persona very, very strongly to the kind of work that I do, and therefore the value or how I perceive the value of the work I do . . . following that job loss I fell into some terrible depressed times . . . I ended up taking manual labor jobs for 12 dollars an hour, minimum wage, and I really haven't felt that I've been suitably employed ever since, and I've gone from job to job to job.

Graham cited workplace stigma around mental illness as contributing to his isolation in asserting, "It falls under the same category as being diagnosed with diabetes, or epilepsy or whatever but I always feel separate or different than the people around me, and feel that I'm subject to the judgment of people around me." Similarly, Ronnie explained that he left the Army, fearing his ostracism would grow round his mental illness:

> They don't like people being different, but I am different . . . I can fit into the military but the thing is, it's not something I can tell everyone in the military . . . they might be uncomfortable, that's all.

Adding to, and likely reflecting the men's isolation, was their failed relationships and single status. Some participants detailed failed relationships as triggering their suicidality. For example, Pete recounted how his marriage breakdown was the tipping point for his subsequent mental illness, homelessness, and heroin addiction:

> We had a great marriage. I don't know what happened . . . she came home one day and said she was leaving. I had a complete breakdown—meltdown. I couldn't handle it . . . I lost everything. I mean, my whole life was getting that security, and I lost my wife, and my life, everything about 10 years ago. I'm still not recovered from it, still fucked up.

While unforeseen by Pete, other men purposefully avoided relationships because of their suicidality. Eric suggested:

> The advantage of being single and suicidal is you don't really feel the obligation to put up a face. Like sometimes when you're in a relationship, you feel like you need to be the one who's the "rock," the one's who's holding things down.

Malik declared, "I had prostitutes . . . because you could get yourself hurt emotionally if a woman leaves you or breaks your heart." Within the subgroup of single men ($n = 15$) evident was their distance from intimate relationships for fear of being inadequate and/or vulnerable.

Self-isolating was also explained by men as strategic in protecting others and/or themselves from their low affect and suicidality. Owen suggested, "I don't personally want to be the guy bringing the group down so, I'll head out and explore on my own." Owen, and many other men, drew on masculine ideals in steadfastly avoiding being burdensome on others, choosing instead to self-isolate to protect others. Participants also revealed deliberate efforts to isolate as a self-protection strategy. Russell explained that he withdrew from friends and family to govern against noxious stimuli as a means to quelling his cyclic depressive symptoms and suicidal thoughts:

> I cut them off, ignored them, didn't answer their phone calls or e-mails because I'm upset that I'm upset . . . if I get pissed off, I'm pissed off that I've let somebody else get to me, or caused me to be pissed off. Now I'm mad at myself, I'm not mad at them.

Russell inadvertently distanced himself from potential supporters by self-isolating, perceiving engagement with them would further challenge his efforts to control his thoughts. In terms of structure, external societal stigma informed some men's self-isolation. Ricky asserted:

> If you're odd, if you're too thin-skinned, if you're schizophrenic or whatever the hell it is that your major

> challenge is that you don't fit into a very competitive society . . . it's really easy to see how you don't matter and much more difficult to walk that road of saying, "well, you know, just matter to yourself."

While protection of others and self was consistently cited by the men as informing their self-isolation, there was also evidence to suggest that these strategies responded to hegemonic masculine ideals wherein the limiting of men's disclosures was relational and reciprocal, as Pete affirmed:

> Suicide especially, or depression—I don't like talking about stuff like that, because it's negative, and nobody wants to hang around people who are down, depressed, or whining. So, to me it's sort of, why do I want to put that on somebody else when I hate it when people put it on me?

While isolation might be used to avoid or limit the visibility of one's vulnerabilities, retrospectively, men conceded that isolation heightened their risk for suicide. As Russell admitted, "When you isolate you incubate your feelings. And you don't share it with people, then . . . your self-talk is all going to be that hamster wheel." In sum, men's isolation, driven by self and societal stigmas took them away from potential supports rendering them likely to hide and/or hurt themselves.

Discussion and Conclusion

The current study findings provide much needed discernments about the connections between masculinities and men's experiences of suicidality. Defining and distilling injury, interiority, and isolation as intertwined within and across a diverse sample of Canadian-based men, provides context for previously indicated individual-level risk factors for suicide including a history of being abused as a child (Easton et al., 2013), single marital status (Yip et al., 2015), and job loss and financial difficulties (Coope et al., 2015). Offered also are insights into men's experiences of suicidality that support previous findings while advancing masculinities and suicidality work (Alston, 2012; Braswell & Kushner, 2012; Cleary, 2012; Coleman, 2015; Emslie et al., 2006; Granato, Smith, & Selwyn, 2015; Oliffe et al., 2012; Russell & Toomey, 2012). Specifically, the current study offers new empirical, theory-based, and methodological insights arguing that requisite to addressing men's suicidality are nuanced understandings about the connections between masculinities and injury, interiority, and isolation.

Empirically, in terms of injury, hegemonic masculine ideals espousing men's resilience to, and stoicism regarding their traumas, likely fueled the predominance of participants' escapism through the overuse of alcohol and other drugs. In contrast, disclosing injuries and explicitly talking to their emotional impact risked ridicule and further marginalization. Likewise, ideals of self-reliance and stoicism rendered the interiority of men's suicidality acceptable, and perhaps compulsory, both as a means to concealing and solving one's problems independently. The alternative, seeking help, was often synonymous with weakness. Isolation, while sometimes linked to enigmatic solitary masculine ideals (Oliffe et al., 2013) revealed the lack of masculine capital endured by many participants wherein employment, relationships, and mental illness entwined to heighten their separateness and suicidality. The current study findings reveal the power of hegemonic masculinity to "other" and ostracize vulnerable marginalized men challenged by suicidality. Indeed, vulnerability and injury were juxtaposed with idealized masculinity wherein men's complicity with a "code of silence" in denying such weakness could be a pathway to suicide. While presented here as separate themes linkages between injury, interiority, and isolation were ever present within and across the participant's interviews and photographs. For example, injury could be further complicated by men's interiority and/or isolation signaling overlapping relationships between the three themes, and the interconnectedness of the findings.

In terms of application, the current study findings have the potential to highlight ways of addressing gender-related influences on men's suicidal behaviors. For example, it is clear that the full gamut of masculinities needs to be legitimized in waylaying the oppression invoked on men who fail to comply with, or embody hegemonic masculinities. In clinical and conversational contexts, directed questions such as, a lot of men carry injuries, what injury challenges you the most? can provide men explicit permission to talk about their stress and stressors as a gateway to better understanding their social contexts and thought patterns. By asking such open-ended questions, men's challenges can be understood along with their potential for effectively overcoming issues. Likewise, anticipating the connectedness of injury, interiority, and isolation can guide strategies for equipping men to counter suicidality. Increasingly, online and community-based services engage men by building social connectedness to the processes as well as the products delivered in men-centered programs (Ford, Scholz, & Lu, 2015; Hunt, Wyke, Gray, Bunn, & Singh, 2016).

Regards theory-based insights, the current study attends to Southworth's (2016) concerns describing marginalized and subordinate masculinities in the specific context of men's suicidality. Indeed, the majority of participants were challenged by mental illness and an array of other marginalizing circumstances flowing both toward and from their suicidality. In this regard, deprivation and men's suicidality featured in power differentials revealing participant's relative worthlessness and

subordinate position within structurally embedded masculine hierarchies. The powerlessness of most participants to change this was especially evident. While Connell's (1995) masculinities offers much, Evans, Frank, Oliffe, and Gregory's (2011) integrated social determinants of health model including social class and socioeconomic status helps more fully understand men's ineffectual self-management, underachievement in career, and relationship(s), and/or being chronically injured and/or injury prone. In line with Evans et al.'s (2011) suggestion augmenting Connell's (1995) masculinities framework to advance empirical analyses, and the application of findings toward remedying men's suicidality will likely advance the field.

Specific to methods, the current study adds to an emergent body of photovoice and photo-elicitation work addressing men's health issues including prostate cancer (Oliffe & Bottorff, 2007) and young men's grief following the unexpected death of a male peer (Creighton, Oliffe, Butterworth, & Saewyc, 2013). In line with Affleck, Glass, and Macdonald's (2012) review, participant-produced photographs proved potent drivers for men's talk. Moreover, the photographs provided platforms for men to elaborate on sensitive issues and thoughts that can be challenging to articulate in words alone. While only three photographs were shared in the current article, a larger collection of participant photographs are available online and at "in-person" exhibitions with the aim of destigmatizing men's mental illness and lobbying male suicide prevention programs (http://www.manupagainstsuicide.ca/). The participant photographs and accompanying narratives have already reached thousands of people through these forums, making available authentic firsthand experiences with the effect of inviting viewers to share their perspectives, and contribute to conversations about men's suicide. In providing permission and a "place" for such discussions to occur, the photographs make audible a chorus of destigmatizing voices disrupting silences and the censoring of men's suicidality. The men's photographs and words also reveal participants strength in speaking up. Herein, photo-elicitation processes and the photographs themselves can disrupt hegemonic masculine ideals regards what men talk about, as well as how they say it.

Regards limitations, the current research may have benefited by additional purposeful sampling to enable cross comparisons (e.g., gay and straight men, employed and unemployed, single and partnered) to distil variations and the interactions of gender with other social categories on the themes presented in the current study. Of course, this limitation can be addressed in future men's suicidality studies by testing the reach of the injury, interiority, and isolation themes presented here to subgroups of men with elevated rates of suicide including gay and bisexual men and First Nations men. By distilling patterns and diversity within and across such vulnerable subgroups, suicide prevention programs can be more fully tailored.

In conclusion, suicide is deeply gendered, and upstream efforts are needed to effectively act on men's suicidality. After all, men's suicidality and suicide profoundly affects many people including women, children, and other men. So while advocating intervening directly with men, by reducing men's suicide "we" will all benefit.

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