

WHAT'S MISSING For MEN AT THE MARGINS?

**A SMALL-SCALE GROUNDED THEORY STUDY OF
ADULT MEN'S EXPERIENCES OF DEPRESSION,
SELF-HARM AND SUICIDE**

Dilip Balu

**Social Work Student
Charles Sturt University
&
Centacare Sydney
Life Links for Men Project**

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*Raw on a cliff, a rock
Sits ragged under the sky. Years
Wash its shell with torrents and
Winds that massage its hide until
Shadows melt from its emerging curves,
Warmed in beams from an unknown
Dawn, the impenetrable releases its sculpture,
Ever-changing, always becoming itself.*

– Louis Allen Cerulli

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Introduction

Background

In recent years, greater attention has been directed toward men's health in Australia (Wadham, Bentley & Booth 1995). This has been due primarily to the publication of research that has highlighted significant gender differences in health status (Fletcher 1995). According to official statistics, men's suicide rates are significantly higher than those of women, particularly in the 15–44 year old age group (James 1995). Between 1992 and 2002 in Australia, the male standardised suicide death rate was higher than the female rate by approximately four to one (ABS 2002). In addition to this, there are differences in patterns of drug misuse between men and women. For example, levels of alcoholism are higher in men than women (Connell 1998). Men, however access healthcare services around 26% less than women (Connell 1998). These developments have led to policy initiatives such as the National Suicide Prevention Strategy and its resulting projects, such as the Life Links for Men Project at Centacare Sydney. This project provides the context for this study.

Despite the aforementioned developments in men's health, a review of available literature reveals a relative dearth of action-oriented research material in the area of men's **experiences** of mental health. This may be caused by the interaction of numerous factors including, but certainly not limited to the influence of 'masculinity ideology' and the fact that men's health has historically been seen as the standard for overall health care in this country. This has led policy makers to falsely assume that men's health does not require specific attention (James 1995; Fletcher 1995). The opportunity therefore presented itself to conduct objective and detailed exploratory research into a sample of men in order to try to understand their characteristics and experiences better. This improved understanding may then contribute to enhanced service delivery.

Research Setting

This project was conducted as part of a 50-day student research placement at Centacare Sydney's Life Links for Men Project. This project involves the provision of specialist counselling and advocacy to men where serious self-harm is a concern. The principal researcher was the social work student on placement. Life Links is conducted at the intersection of two large and dynamic areas of health service provision, namely mental health and men's health. This means that the project's target group (25–44 year old men with serious self-harm issues) are members of a social group that has historically suffered a dual-disadvantage in the context of health, related to health and gender status (Fletcher 1995; Ball 1991). When speaking of gender status I am referring not only to biological differences between men and women, but also the structural aspects, which are made up of social behaviour, cultural patterns and social institutions (Connell 1998). Dual-disadvantage refers to both the differences in health outcomes between men and women, such as those mentioned earlier, in addition to the aforementioned social, cultural and institutional aspects that have traditionally viewed men's health as not requiring specific attention (Fletcher 1995; Ball 1991; Connell 1998).

For the purposes of this study, self-harm is defined as follows:

1. Suicide attempts
2. Suicidal ideation
3. Deliberate self-harm (e.g. self-injury, self mutilation)
4. Harmful lifestyle habits (e.g. excessive gambling, substance misuse, indiscriminate sexual behaviour).

This is the definition of self-harm used for the Life Links Project at Centacare Sydney, of which the clients sampled for this study are part (see Appendix 3 for further details).

Conceptual framework

The goal of this particular research was to identify and analyse patterns that emerge in client's experiences. This was undertaken in the hope of stimulating further research aimed at improving access to specific services for 25–44 year old men with serious self-harm issues. This research goal is not without subjectivity on the part of the researcher, however since this research is action-oriented, it cannot be without some ideological basis; in this case social work ethics and principles (Fook 1996). The research is client-focussed, as opposed to researcher or agency focussed. As far as possible, client experiences have driven the research, and these same clients are the

intended beneficiaries of any policy change that may eventuate from the research (Alston & Bowles 2003).

There is a need to find answers to the question of why men's suicide rates in Australia are approximately four times higher than women (Russell & Judd 1999). This need forms the basis of recent federal and state government policy directed at various mental health projects that are targeted toward men. Research has highlighted risk factors for suicide such as depression, alcohol and other drug use, unemployment, homosexuality, and choice of suicide method (Moller-Liemkuhler 2002). However, there is a case for further research aimed at exploring these factors at a deeper and more personal level. That is, research that uncovers underlying themes in relation to men's unique and shared experiences from a humanist existentialist point of view (Russell & Judd 1999; Payne 1997). This case is based on a feminist tradition of qualitative inquiry that has successfully highlighted the link between private or personal issues and public problems, and the apparent lack of this sort of research in the area of men's mental health (Payne 1997). It is also based on Foucaultian thought in relation to the complexity of diffuse power relations between the 'private' and 'public' spheres of life (Donzelot 1980). An overarching principle of this type of research approach is to not limit exploration to highlighting risk factors, pathology and personal deficits, but to go further and explore the complex links between individuals and their social environments (Payne 1997). In other words, the approach taken is one that aims to combine a universalist or humanist approach focussed on human rights and social justice with a postmodernist, relativist approach focussed on analysis of discourse (Ife 1997).

Methodology

Data Collection

Due to ethical concerns surrounding the interviewing of clients with complex issues by the principal researcher (being an undergraduate social work student), a **secondary analysis of eight Life Links client files** was chosen as the most appropriate methodology to use in order to indirectly explore client experiences. Client files were selected based on the following criteria:

- Sex (only clients identifying as male)
- Age (only clients 25 yrs old and over were considered)
- The presence of self-harming behaviours on the part of the client
- The number of pages of notes – Files ranged from 7 – 38 pages in length (Average of 23 pages per case file)

These criteria were devised by the principal researcher and the placement supervisor and were followed strictly to try to ensure maximum generalisation of findings. The sample number of eight files resulted from following these criteria.

The overall approach also included the experiences and opinions of relevant staff working with the targeted client group, thereby facilitating a holistic view of any emerging issues. This was done via **semi-structured interviews with eight human service workers** (see appendices 1 & 2 for details). Interviews ranged from 20 – 60 minutes in length, and the principal student researcher collected data via thematic notes and supplementary tape recording for detailed post-interview analysis (Alston & Bowles 2003).

Participants

As mentioned above, the selection of files for analysis was not based on demographic criteria alone, but rather on an already limited selection of available Life Links for Men clients (n=27) and the above criteria.

All men studied fit into Life Links' definition of self-harm, and their ages varied from 25 – 64 years old, with an average age of 39.5 years. One of the men was from a Greek-Australian cultural background, while the other seven men were from a white Anglo or Celtic background. None of the men studied identified as being of Aboriginal and Torres Strait Islander descent. At the time of initial engagement in counselling services, two of the men studied were employed, and only one of the men was in a stable relationship with a partner. None of the men identified as being homosexual or of transgender status.

The principal researcher selected the human service workers to be interviewed with the assistance of the Life Links Specialist Counsellor. A database of related local services was used and contact was made via phone, fax and email with a number of agencies and individual workers, from which the final sample of eight workers emerged. The interviews were conducted with six male workers and two female workers from various human service agencies within the Centacare Sydney geographical area. The workers interviewed practiced within public mental health, general non-government welfare, family law, and homeless services. The workers' years of experience in their current fields ranged between 5 and 14 years. Workers' own descriptions of their roles included counselling, mediation, case management, group work, and outreach.

In accordance with research ethics, all the individuals whose experiences and/or comments are discussed have had their names coded and/or changed to ensure confidentiality.

Data Analysis

The research was designed to be non-linear and inductive in nature, utilising **grounded theory** analysis to help stimulate further exploration of the topic, rather than coming to any final conclusions and/or recommendations based on theoretical assumptions (Fook 1996; Glaser & Strauss 1973). Case files were read individually, notes were taken and initial categories were identified. As each new file was read, new data was compared and contrasted to existing data and categories were refined through the addition of new properties. Throughout the process, memos were recorded separately to take note of any ideas, theories and general thoughts as they arose. From this process arose the themes that are listed in the research findings section below. These themes were chosen based on the frequency of their appearance during data analysis, and their ability to incorporate other data within them (Glaser & Strauss 1973).

This methodological framework was chosen because the ideology underlying grounded theory best matched the ideology of the principal researcher (Glaser & Strauss 1973; Dey 1999). The experientially focussed, and emergent nature of this qualitative methodology suited the principal researcher's need to explore individual experiences of social phenomena as they emerged. This helped to guard against allowing preconceptions of the social phenomena in question (men's serious mental health concerns and associated factors) to dictate the way that the research was carried out (Glaser & Strauss 1973).

Research Findings

In this section, I will briefly outline the main themes and properties that emerged from the secondary analysis of client files and worker interviews. These brief overviews are only intended as an introduction, and the theoretical richness of each theme, including their interconnections will be discussed in the next section.

Emergent Themes

1. The meaning of masculinity to the individual – CORE THEME

This theme included the following major categories:

- Social, cultural and familial expectations: normality and deviance
- Self perception and the subjective experience
- Emotional expression and help-seeking

2. Social disconnection and exclusion

- The experience of depression
- The service system for self-harming men: inclusive or exclusive?
- Relationship and family breakdown
- Employment and housing

3. The 'situation maintenance' cycle

- Critical entry points – stress triggers and existential crisis
- Self Harm – coping with pain (physical and mental)
- Social isolation
- The self-fulfilling prophecy of 'relapse'

4. The 'safe space'

- The legacy of loss and trauma
- In the present – acceptance, trust and hope
- The role of relationships in men's lives

5. Diversity and the subjective experience

- Sexuality, ethnicity, social class, spirituality, etc.
- Agency and capacity for change
- Complexity and the need for long-term, continuous and intensive service engagement

6. The role of social support

- The need for stability to aid transition and change
- A sense of belonging and worth – social reintegration/reconnection
- Hope for the future

Discussion

Limitations of the study

The small sample size of eight men's files and eight worker interviews, along with the limited cultural and sexual diversity of the men may limit the generalisation of the study's findings.

In addition, the qualitative methodology chosen is subjective in nature, and may therefore also be open to question in relation to generalisation of the findings. The client file notes are presented through the eyes of the counsellor, which may see them open to interpretation and selectivity. However, the files notes are detailed and descriptive in nature, as opposed to explanatory, which helps to limit this potential bias (Alston & Bowles 2003). In addition to this, all research, whether qualitative or quantitative is somewhat dependent on the subjectivity of the participants and the principal researcher in relation to the way research is designed and data is collected and analysed (Holliday 2002). The strength of the qualitative approach is that it allows for people's actual experiences of social phenomena to be explored and presented, thereby allowing for a more participatory approach based on deeper exploration of these phenomena through the eyes of people themselves (Holliday 2002).

Another limitation that requires acknowledgement relates to the resource limitations faced by the principal researcher in this case. Available time was limited to 30–40 days, and resources were limited in terms of personnel and finances. This meant that the rigour of the research was affected in relation to sampling (data saturation through snowballing could not be undertaken due to time restrictions) and the ability to search for disconfirming evidence (Glaser & Strauss 1973).

Finally, the sample chosen was taken from within an already limited pool of available clients. This may also restrict the ability to generalise the findings because the representativeness of the client pool may be limited due to its small size ($n=27$). Additionally, the fact that those sampled were already engaged in counselling, means that they are likely to represent a relatively small proportion of men with serious self-harm issues. This is due to the limited availability of specialist counselling services for self-harm, and men's reluctance to seek help for health concerns (Parslow & Jorm 2000).

Discussion of findings

1. The meaning of masculinity to the individual

Male and female represent the two sides of the great radical dualism. But in fact they are perpetually passing into one another. Fluid hardens to solid, solid rushes to fluid. There is no wholly masculine man, no purely feminine woman.

Margaret Fuller (1810 - 1850), *Woman in the Nineteenth Century*, 1845

Although masculinities are varied in nature according to culture, class, sexuality and other forms of diversity, a hegemonic form of masculinity does exist in western culture and affects men in their day-to-day lives (Connell 1995). The Foucaultian school of thought sees this hegemonic form of masculinity as having its origins in the social control apparatus of western society (Donzelot 1980). It is shaped to fit into the currently accepted constructions of the family and related spheres of employment, education, health and welfare. The goal of this hegemonic construction of masculinity may be to maintain the status quo of social and economic relations (Donzelot 1980). Hegemonic masculinity emphasises gender hierarchy, heterosexuality, breadwinner status, authority, and rationality, amongst other things (Connell 1995). Within the established gender order of Australian society, gendered and other power relations can conflict with these accepted constructions of masculinity at the level of individuals (Connell 1995).

▪ **Social, cultural and familial expectations: Normality and deviance**

The findings of this study revealed a common inability to fit into conventional hegemonic constructions of masculinity (Halkitis 2001). All of the men who presented to the Specialist Counsellor at Life Links for Men talked about life experiences that threatened their masculinity. Experiences such as divorce, lack of access to their children, victimisation, physical injury, disability and associated care dependency characterised these men's stories. These life experiences constituted a threat to each man's individual conception of masculinity based on breadwinner status, authoritativeness, rationality, control and heterosexual expression (Connell 1995). This threat is well demonstrated by the case of one of the men, 'Craig' (not his real name – NO REAL NAMES ARE USED IN THIS REPORT).

Craig saw himself as needing to fulfill the protector role and “provide no matter what” for his family. For him this personal conception of masculinity meant that his “own needs come last” (Source: file CS411).

Functionalist sex role theory sees conformity to norms of hegemonic masculinity as promoting psychological adjustment (Connell 1995). The cases analysed in this study demonstrate the utility of a more Foucaultian argument that normative sex role theory is itself a form of gender politics aimed at preserving social control over men by shifting from external to internal controls over behaviour (ed. Rabinow 1986; Connell 1995). By achieving this, social change can be avoided and a contribution can be made to maintaining the status quo of social relations (ed. Rabinow 1986). The case of ‘Jeff’ demonstrates this argument most effectively.

Jeff is 40 years old and experiencing separation from his wife and children, and job loss concurrently. In addition to this, he has a history of physical injury, most recently a motorbike accident, which resulted in fractured vertebrae and time off work. Jeff demonstrated the self-blame and depression that was commonly present for all of the men studied when at one point he expressed his belief that “everything is my fault” in relation to his separation from his wife and loss of contact with his son. Jeff expressed feelings of rejection through his belief that “people didn’t care for years” and that his trust had been breached in his previous and current relationships. Jeff’s ability to be a provider and protector for his family had been adversely affected by a series of losses of physical function, social role and life opportunities, which resulted in stress, depression, suicidality and self-harming behaviour. However, despite these losses Jeff expresses a real sense of personal failure and individual responsibility for his current situation (Source: file CS401).

Jeff’s case illustrates the feelings of personal responsibility and deficit shared commonly by all of the men. These feelings appear to be related to a perceived failure to successfully negotiate hegemonic constructions of masculinity, and resulting conceptions of what it is to be a ‘normal’ man.

- **Self-perception and the subjective experience**

Findings from interviews with human service workers also supported the need for a sense of purpose associated with the successful personal construction of masculinity to fit hegemonic social constructions. This sense of purpose could be achieved primarily through stable employment and family relationships. One worker (‘PLO2’) summarised his experience in relation to family dissolution and its impact on men as follows:

Male identity is bound up in lots of things, but quite often, being the provider, being the leader, being the protector and all of those things quite suddenly can be wiped away.

The experiences of the men studied here seem to be part of a process of personal reconstruction of identity that is based on integrating personal and social change. For many of the men, a sudden change in life circumstances, such as divorce and job loss triggered an existential crisis based on a challenge to the very foundations of identity and reality (Herman 2001).

- **Emotional expression and help seeking**

For one man 'Chris', the end of his marriage resulted in significant feelings of loss, which were exacerbated by his difficulty in expressing his feelings. Chris' form of expression was verbally abusive, and his alcohol use became a way of coping with his mental and physical pain. His alcohol misuse also helped him to cope with feelings of profound dislocation and loss of purpose in life (Source: file CC501).

For Chris and the other men, it became apparent that the life choices presented to them seemed fraught with the risk of social rejection. For example, being depressed, emotionally inexpressive, self-harming, or outwardly aggressive and abusive due to unresolved emotional pain is anticipated to lead to social stigma and rejection. This may well be due to the effects on self-perception of a lack of control and rationality of behaviour; control and rationality, which is required by hegemonic masculinity and also by normative discourses related to mental health (Connell 1995; ed. Rabinow 1986). However, taking the choice to outwardly express feelings in an effort to deal with this unresolved emotional pain and depression is also likely to result in social stigma and rejection. This is due to a deviation from the very same accepted norms of masculinity (Connell 1995).

Chris' case illustrates the apparent compatibility of normative constructions of both masculinity and mental health in achieving social control over men. This Foucaultian catch 22; or 'double-bind' dilemma that faces men was the major finding of this study, and will be discussed further in relation to the themes that follow (Moller-Liemkuhler 2002). In addition to this, Australian contemporary society and culture is dominated by western discourses of individualism as opposed to collectivism (eds. Alston & McKinnon 2001). These discourses have seen the family achieve predominance as the social institution most responsible for the welfare and socialization of individuals (Donzelot 1980). A common thread running through the stories of these men is family relationship difficulties and/or breakdown. Without the availability of a protective family environment these men found themselves dealing with

their emotional pain unsupported and in relative isolation. This only served to compound the 'double-bind' dilemma already being faced.

Masculinity is a relational concept because there can be no concept of masculinity without the concept of femininity (Connell 1995). Hegemonic masculinity is complex and diverse in nature, as described by one worker ('RL02'):

In a sense in our culture, we bring men to a place where there's a set of cultural rights about life – whereas with women, life's always more problematic and there's a logistical step-by-step process.

In this way, hegemonic masculinity is broadly positioned in relation to femininity and the different cultural concepts that shape both men's and women's experiences. These concepts affect men's ability to deal with critical life changes that challenge these accepted cultural rights.

The same worker, ('RL02') also mirrored the feelings of the men studied, and workers interviewed when he described the impact of hegemonic masculinity on the ability of men to ask for help when facing an existential crisis:

It's almost like if I go and ask for help, I'm gonna' be weak, then I won't be a man, then everything unravels.

In this way, the subjective conceptions of masculinity that each of the men hold serve as overall frameworks for social relations within which behaviour is shaped and defined. These subjective frameworks can in turn be linked to various efforts and levels of social control that produce discourses of masculinity: discourses that are aimed at preserving the existing social order of families, communities, and social institutions via internal regulation of behaviour (Donzelot 1980).

2. Social disconnection and exclusion

Without friends no one would choose to live, though he had all other goods.

Aristotle (384 BC - 322 BC), *Nichomachean Ethics*

As mentioned above, the men in this study appeared to share a double-bind created by the conflict between their lived experience of mental health problems (particularly depression) and the behavioural requirements of masculinity. These behavioural requirements included, non-expressiveness,

reluctance to seek help, and alcohol and other drug abuse (Moller-Leimkuhler 2002). The lived reality of this double-bind for the men in this study was social disconnection, exclusion, and resulting isolation due to the inability to fit into accepted socially defined roles (Charon 1995).

- **The experience of depression**

Depression was reported as the primary mental health problem of all eight of the men studied. The prevalence of depressive disorders in the general population is about 5% internationally, and around 2–4 % for men (eds. Hawton & van Heeringen 2000). In Australia, the one-year prevalence rate for depressive disorders is estimated to be approximately 6%, and women are around twice as likely as men to have a depressive disorder (Commonwealth Department of Health and Aged Care 2000). Suicidal behaviour is a feature of all forms of depression (eds. Hawton & van Heeringen 2000). Men's experiences of depression in the context of this study were characterised by a **cyclical relationship between antecedents to depression**, (e.g. trauma, relationship breakdown, grief and loss), **depression itself** and associated suicidal and self-harming behaviour, **and the social consequences of depression and associated behaviour**. The social response from family, friends, and institutions displayed varying degrees of acceptance according to the men; however the general feeling of the men themselves was one of rejection.

The meaning of depression as experienced by these men can be illustrated well by examining the case of 'Simon'.

Simon is 30 years old and his life experience has been marked by childhood trauma, disrupted family relationships, loss of partner and friends to suicide, severe self-harm (cutting, hanging, poisoning, drug abuse), and exclusion from mental health services. Simon has struggled with depression and intense emotional pain related to trauma and loss. He has found self-harm to be therapeutic because it provides an emotional release for him, which he has not been able to find any other way. Simon's family relationships have been disrupted by trauma related to sexual abuse, and this lack of family support, combined with his depression, self-harm, and suicidality have resulted in disconnection from 'normal' social relationships. Simon received a diagnosis of Borderline Personality Disorder (BPD) from public mental health services, which has resulted in him being labelled as possessing anti social traits, and therefore effectively excluded from receiving services within the public mental health system (Source: file CC301).

Simon's experience illustrates the way in which men suffering from depression, suicidality, and self-harm can find themselves disconnected and excluded from 'mainstream' society and left without a 'social safety net'.

- **The service system for self-harming men: inclusive or exclusive?**

The biomedical model of mental health service delivery in Australia is characterised by diagnostic labelling of individuals as they come into contact with services (Isaacson & Rich 2001). This reality was confirmed by human service workers interviewed for this study from both within and outside public mental health services. One worker ('GC02') described the gradual systemic shift over the past 30 years from a focus on neuroses to a focus on psychosis, which has effectively been a shift toward the 'acute' end of the diagnostic continuum:

What we are looking at are people on the psychotic scale and people where the behaviours that they are exhibiting mean that the illness and its manifestations can't be managed in that person's normal living situation.

As described by another worker ('LB02'):

Affective disorder clients are seen as counselling clients that social workers need to take on in addition to their existing case load if they wish to.

Effectively, this means that for men whose diagnostic label does not fit into the psychotic scale, services will only be made available to them at the discretion of individual workers. Men like those in this study appear to have come to an abrupt halt at the intersection between the biomedical and economic rationalist models of healthcare service delivery. For these men, fitting a diagnostic label is not the only requirement, but availability of services is also rationed based upon the 'severity' or 'acuteness' of the illness, not the unique need of the client. For men like Simon, the onus is placed on him to seek help, when evidence suggests that men do not readily seek help for health problems (Dear, Henderson & Korten 2002). In addition to this, the majority of services available to men like Simon are available on a private, fee-paying basis. For the men in this study, and others like them for whom unemployment and resulting socio-economic disadvantage are a reality, private psychiatric services are often out of reach.

As noted by another worker ('CW02'), not only do many male clients he sees indicate difficulties relating to professionals, such as psychiatrists, but:

If you're willing to pay, you can get anything, but if you haven't got the money...access to good professional services is difficult.

For men themselves, the diagnostic labelling that accompanies engagement in public mental health services can contribute to feelings of rejection and isolation from society. The symbolic interactionist perspective emphasises the negotiated nature of subjective reality, and the importance of social interactions in forming identities and social roles (Charon 1995). For a man like Simon, being labelled as having BPD, and excluded from mental health services due to 'anti-social traits' is likely to have the effect of reinforcing the rejection and shame of a lifetime, thereby contributing to his negative self-perception, sense of hopelessness and depression.

- **Relationships and family breakdown**

Difficulty forming and maintaining relationships was a common theme amongst all of the men studied here. One man's case in particular illustrates the disconnecting impact of relationship breakdown.

'Frank' is a 50-year-old man who has displayed increasingly poorer and poorer self-care since his divorce three years prior to attending Life Links for Men. Frank has been estranged from his wife and children and has had an Apprehended Violence Order (AVO) taken out against him which prevents his from being in physical proximity of his family. Frank's weight has dropped significantly, and he has feelings of betrayal toward his ex-wife, and both the services she attends and the services he has been excluded from. Frank has been excluded from services due to 'inappropriate behaviour' and suffers from depression (Source: file CC501).

For men like Frank, loss of marital or other intimate relationships, in addition to the lost role of father, provider and protector results in feelings of loss, rejection, betrayal and isolation. The double-bind referred to earlier in relation to masculinity and mental health, combined with the institutional response of health services, family law, and police serves to exacerbate the isolation that is already being felt. This then has the effect of disconnecting and excluding men further.

'PL02', describes the importance of the institutional response to men's distress associated with family breakdown:

I think that men are showing their feelings, are showing their sadness, but just in a different way and it's important to be able to pick it up It's not a conventional weepy..... (show of emotion).

As mentioned earlier, in our relatively individualistic society the family has been constructed to act as the predominant social unit for the connection of

individuals to wider social relations and norms. (Donzelot 1980) The family therefore serves as a space for identity formation and self-expression (Donzelot 1980). For the men in this study, the lack of generally stable, healthy relationships with parents, siblings, partners and children had the effect of removing a vital source of support to help counter vulnerability to the negative impact of stressful life events (Weiss 1985). However, as will be discussed later on, the establishment, or re-establishment of healthy relationships with family and friends helped to re-connect some men and provide a sense of purpose in life.

▪ Employment and housing

Unemployment has been recognised as an important factor in men's mental health (Jorm 1995). As mentioned earlier, hegemonic constructions of masculinity emphasise breadwinner status and competitiveness as important attributes to being a man in western society (Connell 1995). Also, the structure of capitalist society places a great deal of emphasis on being employed in relation to social, economic and cultural participation through production and consumption (Payne 1997).

For the six men studied who were affected by unemployment, the lack of paid work had an effect on their financial status, and therefore their ability to participate actively in society. Studies have found that in Western countries, a significantly higher number of adults with mental illness live in poverty compared to other non-disabled people (Wilton 2003). For the men in this study who were unemployed, their mental health status served as a restriction to social participation due to its disabling effects on self-esteem, energy levels and social interaction. In addition, the structural barriers of low socio-economic status, social stigma, the lack of affordable or accessible services (counselling, housing, employment) as well as limited employment opportunities also served to restrict opportunity. The result of this interaction between disability and structural factors was to reinforce existing social disconnection and exclusion at all levels: physical, mental and structural.

For one man 'Michael', being unemployed meant that he was unable to afford to move out of home and be independent. At 33 years old, Feelings of inadequacy and worthlessness formed during childhood and adolescence related to bullying, victimisation, and overprotection by his mother were more difficult to resolve due to his inability to find employment and move on to the next stage in his social life. In addition, an important source of social support and interaction was unavailable to Michael, the impact of which he felt as loss at the level of personal growth and life opportunity. The results for Michael were feelings of self-blame and worthlessness, worsening depression, and

self-harm in the form of cutting. Michael expressed his self-concept by saying things such as; “I’m worthless”, and “nobody likes me and I’m going to be lonely for the rest of my life” (Source: file CS331).

The benefits of employment, such as improved financial status, social role and purpose, and accompanying life opportunity did not however provide a mental health buffer for the two men studied that were employed. For these two men, paid work was a source of both strength and stress.

For ‘Craig’ (mentioned earlier), work provided a strong source of cultural, familial and personal reinforcement related to his constructions of masculinity. However work role transition due to workplace injury, financial pressures, and the need to perform the role of carer for his wife, all meant that the status of being employed and earning money did not directly translate to being a successful provider and protector for his family. For Craig, fulfilling the traditional male role was not enough to protect against family conflict and stress. This was enough to throw Craig into a state of existential crisis related to a sense of failure in his negotiated social role (Connell 1995; Charon 1995) (Source: file CS411).

This case helps to illustrate the importance of diversity and subjectivity of life circumstances in the creation and maintenance of these men’s situations. This will be discussed in more detail later on.

For the men involved in this study, homelessness was not generally a major concern. Seven of the eight men were living in stable accommodation at the time they were attending counselling at Life Links. One man was in the process of securing stable accommodation post prison-release. His case illustrated the importance of accommodation in forming stable social relationships and maintaining adequate physical and mental health. The future goals of all of the men included forming healthy and positive relationships. Through their experiences, all recognised the importance of mental & physical health, employment and housing to achieving this. A decent place to live is a primary human need, and in Australia, the majority of homeless people are men suffering severe and often chronic mental disorders (Jorm 1995).

Interviews with workers practicing in the area of homeless outreach in the Centacare Sydney geographical area helped to crystallise the commonalities between the clients they see and the men studied here. Workers ‘KL02’ & ‘CP02’ both indicated that substance abuse, relationship breakdown, childhood-related trauma and diagnostic labels, such as personality disorder were the most common themes they encountered in relation to their clients

(around 80% of whom are men). 'KL02' summarised her feelings toward her homeless male clients as follows:

At any point in time any of us could be in the same situation.... their ability to survive is just amazing.

Although homelessness was not a common issue for the men studied here, this is not surprising when you consider the fact that these men are only involved in this study because they have actively sought help through the Life Links Project. The homeless service workers interviewed highlighted the importance of outreach services in order to try to fill the gap in the service system for homeless adults. They indicated that the structure of the service system for homeless adults does not account for the cyclical nature of their situations. The social exclusion faced by homeless people is at the most extreme end of the continuum where the doors and bridges to accessing services have often been closed and burned. In the opinion of the workers, this is due to the onus being placed upon homeless people themselves to access available services without assistance. This situation is made almost impossible to negotiate due to the numerous barriers faced by homeless people, such as poverty, mental and physical illness, and social stigma (Wilton 2003).

If we examine the cases of the eight men studied here, seven out of the eight had stable housing, and for the other man, probation and parole services acted as a referring agent. So what then makes the difference in the cases of the men studied here? Why are they able to access services? Why is homelessness still relevant to these men's experiences? Although social disconnection and exclusion were a reality for them, stable housing meant that the levels of disconnection and exclusion experienced were not as extreme as they would be if they were dislocated further through homelessness. This meant that existing social supports in the form of family members and social institutions helped provide the connections that each of these men required to enable them to access assistance beyond that available through public health services.

The aforementioned discussion of the importance of housing, employment and service access also raises questions of human rights. A human rights-based discourse built around the three generations of universal human rights emphasises the importance of not only legislated civil and political rights, but also social, economic and cultural rights (Ife 2001). For the men involved in this study, the impact of service exclusion due to diagnostic labelling could well be viewed as a breach of social human rights related to adequate access to health care (Ife 2001). For homeless men who suffer relatively greater social disconnection and exclusion, their lack of housing and employment opportunities could also be viewed as breaches of social and economic rights

(Ife 2001). This view helps to emphasise the need to broaden the perspective on men's mental health from that of individual pathology, to that of social contract and justice (Ife 2001).

3. The 'situation-maintenance' cycle

I hate to advocate drugs, alcohol, violence, or
insanity to anyone, but they've always worked for
me.

Hunter S. Thompson (1939 - 2005)

In examining the stories of the men studied here, it quickly became apparent that their situations were cyclical in nature, and that certain factors commonly contributed to the maintenance of each man's situation. In all cases, change was difficult to achieve, and this appeared to be related to the double-bind of masculinity and mental health, which served to control the individual by limiting change (Connell 1995; ed. Rabinow 1986).

In all cases, existential crisis appeared to precipitate self-harming behaviours. These existential crises were in turn precipitated by stress triggers such as relationship difficulties, conflict, physical illness, and other environmental stimuli, e.g. media, and social events (anniversaries, holidays, etc.) (Lazarus 1984). For these men stress was being created by emotions related to underlying grief and trauma being brought to the surface by these triggers. Each of the men's responses varied according to their unique life experiences (Lazarus 1984). The existential crises experienced generally resulted in self-harming behaviour aimed at coping with the extreme stress being experienced (Benner & Wrubel 1989). The case 'Frank' (mentioned earlier) helps to illustrate this.

Frank's intense and conflicting emotions were brought to the surface by ongoing family law dispute and the inability to see his children. As a result, his alcohol use increased along with a reduction in his general self-care in an attempt to cope. Frank's physical health deteriorated to the point of life threatening physical illness. This substance abuse and lack of self-care constituted serious self-harm in Frank's case (Source: file CC501).

Figures show that men are more than twice as likely to have substance use disorders than women, (11% compared to 4.5%) with alcohol use disorders being more common than drug use disorders (ABS 1998). These figures are

interesting due to the fact that the prevalence of diagnosed depressive disorders for men is only half that of women, however substance use disorders are twice as high in men (Commonwealth Department of Health and Aged Care 2000). The intensity of these men's experiences, combined with the restricting influence of their own normative constructs of masculinity and related social role, appeared to result in socially unacceptable means of coping, such as aggression, and abuse of themselves and others (Connell 1995; Charon 1995).

These stress- induced points of crisis did present opportunities for entry into the service system.

For 'Michael' (mentioned earlier), his self-harming behaviour often resulted in trips to the local hospital, which usually ended in being sent home after a brief amount of time (Source: file CS331).

The critical nature of these entry opportunities was well summarised by 'RLO2':

They're at a place where they've backed themselves into a corner somewhere and you've got to try and put a telephone there with an open line in that dark corner with a little light on so he can see it...what we're trying to do is really hard.

A common opinion held by all the workers interviewed was that the service system is not set up to adequately cater for men such as those studied here. As mentioned earlier, diagnostic labelling, service exclusion and lack of resources for appropriate service provision contribute to the maintenance of these men's situations. They do this by allowing these critical entry opportunities to pass by without adequate assessment and/or intervention. For those who are able to gain access to the public mental health system, the biomedical emphasis on acute psychosis as a pre requisite for adequate engagement often means that an expectation of 'relapse' into self-harming behaviour is the norm, rather than the exception. For men such as those studied here, this often means being sent home without treatment.

Fortunately for the men of this study, levels of isolation and disconnection from social institutions were such that they were still able to gain referral to the Life Links Project. However, many other men who are homeless and further marginalised fall through the cracks of the system completely. They may therefore find themselves unable to break their cycle of depression, stress, self-harm and isolation.

4. The 'safe space'

For it is mutual trust, even more than mutual
interest that holds human associations together.
Our friends seldom profit us but they make us feel
safe... Marriage is a scheme to accomplish exactly
that same end.

H. L. Mencken (1880 - 1956)

Another common theme shared by all of the men studied here was the need for a safe space to talk about their feelings. In the last section the factors contributing to the maintenance of each man's situation were discussed. The inability to break cycles of crisis appeared to be related to the inability to access safe therapeutic space where work can be done on expressing and understanding the emotional pain being felt.

As discussed earlier, hegemonic constructions of masculinity do not easily accommodate self-expression and/or help-seeking by men (Halkitis 2001; Moller-Liemkuhler 2002). In addition to this, the men studied here commonly shared experiences of loss and trauma related to childhood abuse, death of friends and/or family members, as well as lost career and other life opportunities. Current treatment models for working with trauma survivors have developed from an increased focus on survivors' experiences as opposed to simply mental pathology (Palmer et al. 2004). The National Survey of Health and Wellbeing found the population prevalence of Post Traumatic Stress Disorder (PTSD) in Australia to be 3.3% (McFarlane 2000). Amongst homeless people in Sydney, the prevalence of experiences of trauma is high, including multiple traumas (Buhrich, Hodder & Teesson 2000). One factor predisposing people to PTSD is the experience of multiple traumas (Buhrich, Hodder & Teesson 2000). Although the focus of the work by the Specialist Counsellor at Life Links was not specifically on PTSD, all of the men studied here displayed indications that they may have experienced multiple traumas related to past physical, sexual, and/or emotional abuse, and/or unresolved grief (trauma related to loss). These experiences of loss and trauma varied in nature and intensity from individual to individual, however the common factor was the emotional pain felt as a result of past trauma and the difficulty expressing this pain (Real 1997).

Examining the case of 'Kenneth' provides some insight into the legacy of trauma and loss.

Kenneth is a 64-year-old man who suffered physical abuse as a child while at an orphanage he was placed at by his mother. He experiences intrusive memories of this trauma and maintains a deep rage toward his mother who is now dead and his stepfather who is still alive. This rage appears to be related to grief over being abandoned as a child and having a career ruined by family difficulties, bad advice and ill health. As a result of this trauma, Kenneth suffers extremely poor physical health related to poor self-care, along with depression, extremely low self-esteem, social isolation, and continual family conflict (Source: file CS641).

Kenneth's case helps to illustrate the need to introduce acceptance into the lives of men whose experiences have been, and continue to be characterised by rejection and social isolation (Levang 1998). Providing safety through acceptance helps men to overcome the barriers to dealing with the legacy of trauma and loss. Safety does this by providing a non-judgemental environment that allows men to be understood and grieve in their own way (Levang 1998). This environment may include one-to-one interaction and/or group interaction depending upon the needs of the man (Palmer et al. 2004). Both past and present models of trauma therapy emphasise the importance of providing safety to people who have suffered trauma (Palmer et al. 2004). Current thought however places greater emphasis on providing information and support to trauma survivors, and focussing on the present rather than processing traumatic events (Deville & Cotton 2004). This apparent need to allow the man himself to drive his own healing is well summarised by 'KL02':

To be perfectly honest, a lot of the time you won't get to the bottom of it. It's something that they've agreed with themselves many, many years ago...it's capped...(they say) all I need you to do is meet my needs when I need them met. So it's like, that's okay.

The findings from both client file analysis and worker interviews were consistent in relation to the need to build trust by providing safety and acceptance, and to not take male clients where they don't want to go. Connectedness through relationships appeared to be a prerequisite to combating feelings of hopelessness by building trust, followed by intimacy, and hope for the future (Levang 1998).

The importance of relationships will be discussed more later, however the following brief quote from 'RL02' in the context of men's groupwork helps to emphasise the recurring connection between relationships and men's mental health:

Generally that theme of relationship breakdown or crisis is there. If it's not, you go looking for it.

5. Diversity and the subjective experience

It's just human. We all have the jungle inside of us.
We all have wants and needs and desires, strange as
they may seem. If you stop to think about it, we're
all pretty creative, cooking up all these fantasies.
it's like a kind of poetry.

Diane Frolov and Andrew Schneider, *Northern Exposure, Mister Sandman, 1994*

It is interesting that in a search for commonality, the theme of diversity and subjectivity emerged as so significant. All of the men studied here shared depression, serious self-harm and suicidality in common. Despite this however, each man's attitudes and feelings toward depression, suicide and self-harm differed temporally and from individual to individual, as did each man's capacity for change. Due to the relative lack of cultural and linguistic diversity in this sample of men, the diversity in conceptions of self-harm and suicide appeared to be most closely related to their beliefs, values, spirituality and social connection.

The symbolic interactionist perspective emphasises subjectivity and the importance of a negotiated reality along with accompanying beliefs and values of the individual (Charon 1995). Although the overall cultural context of this study is western society (specifically Australian society), within this overall context, the cultural, class, spiritual and other backgrounds of individuals contribute to the attitudes they hold toward suicide and self-harm (eds. Hawton & van Heeringen 2000). In an effort to explain the differences found in this study, a number of sources of diversity arose which all revolved around the cultural phenomenon of suicide and deliberate self-harm (eds. Hawton & van Heeringen 2000). Although homosexuality and diverse cultural background were not specific factors relating to the sample of men in this study, diversity of spirituality was. This is well illustrated by the case of 'Steven'.

Steven discovered spirituality through Alcoholics and Narcotics Anonymous meetings post prison release. This discovery provided him with a source strength and meaning, along with important social support. He also initiated and developed a relationship with his girlfriend based on common spiritual beliefs. Stephen's history of relationships was one characterised by disappointment and rejection, which resulted in conflict and violence. "Praying to god" provided

Steven with a way to keep safe and a higher power, which taught him to consider forgiveness and acceptance of others (Source: file CC331).

Overall attitudes toward suicide in western society have shifted over time from tolerance and acceptance to condemnation, and now back to a greater acceptance and need to understand (eds. Hawton & van Heeringen 2000). However, despite this overall attitude, this study has uncovered diversity at the level of individuals, families and institutions primarily related to spirituality. The case 'Michael' (discussed earlier) helps to illustrate the power of spiritual beliefs to mould attitudes and behaviour in relation to self-harm and suicide.

For Michael, the thought of going to hell stopped him from seriously attempting to kill himself. However, Michael was also raised to believe that homosexuality is wrong, and that hegemonic masculinity with its roots in heterosexuality, competitiveness, control and rationality was the only acceptable model of behaviour. For Michael, his spiritual beliefs helped to prevent him from suicide. However the inherently conservative nature of he and his family's spirituality served to place him in a weaker position to negotiate a secure and comfortable subjective reality, a reality that accommodated his difference and inability to fit into inherently conservative, hegemonic masculinity. This left Michael in a situation where his accepted spiritual and cultural beliefs contributed to his social isolation and sense of worthlessness, however also helped to protect him from completing suicide (Source: file CS331).

As discussed earlier, the function of hegemonic masculinity in western society is to control the behaviour of men to help maintain the status quo of social relations (Donzelot 1980). This construction of masculinity fits with hegemonic constructions of femininity, sexuality, and overall family relations to help maintain the existing social order. For the men involved in this study, sexuality, and their expression of it appeared to be very important. The meaning of this varied from individual to individual, however being heterosexual and sexually active with a female partner commonly emerged as important. The inability to express themselves heterosexually appeared to be a source of frustration for many of the men, and this frustration was contributed to by the lack of fulfilling intimate relationships with partners. This frustration may well have been related to the inability to fulfill the requirements of hegemonic masculinity, whether they are heterosexual activity, workplace success, or successful heterosexual marriage and parenthood (Connell 1995). This also raises the question of where hegemonic masculinity fits in relation to homosexuality, and homosexual men. Although this study did not allow for an in depth analysis of gay masculinity, what it did

uncover was the fact that hegemonic masculinity is subjective and complex, and that simply being heterosexual does not guarantee conformity to its norms (Connell 1995).

An interview with worker 'JJ02' did serve to emphasise the importance of hegemonic masculinity in relation to its ability to influence the expressiveness of men who identify with its norms:

Particularly for gay men, there's a different construction of what emotions are. I think in gay men's culture, the expression of feelings is much more common or much more accepted. That's not to say that more traditional views of men's dealing with emotions (don't) still impact, but it does make it more possible for men to express their feelings. We're only talking about men who identify as gay. There are a lot of men who have sex with men who don't necessarily identify as being gay, so therefore may not necessarily have that thing where it's okay to express their feelings.

This quote describes a particular construction of gay masculinity, one in which it is okay to express your feelings. Clearly this form of masculinity upsets another of the norms of hegemonic masculinity, however this does not mean that gay men who are able to express their feelings are not 'manly' in other ways, e.g. successful material providers, or competitive in nature (Connell 1995). This quote helps to highlight the complexity and subjectivity of masculinity and its impact on men's life experiences.

Another interesting question raised by this study is actually related to the lack of cultural diversity in the sample of men studied. Seven out of the eight men studied were of white Anglo or Celtic background. As discussed above, many things, including cultural background will influence the subjective experience of individuals (Prasad-Ildes & Wright 2004). Studies have found that intrinsic spirituality and identification with a distinct cultural group can have a protective effect against depression (Cooper et al. 2001). In white European culture, individualism is emphasised to a relatively greater extent than in many more collectivist non-European cultures (eds. Alston & McKinnon 2001). The men in this study may not appear to be influenced by cultural factors, however their membership of the dominant cultural group in Australia does not necessarily render them immune to cultural effects on mental health. In fact, the combination of gender politics related to the benchmarking of, and resulting lack of attention to men's health, combined with membership of a relatively individualistic dominant cultural group, may in fact result in a dual lived disadvantage for these men in relation to their mental health (Fletcher 1995).

In relation to individual agency and capacity for change, each of the men studied also displayed diversity. All of the men had shown capacity for change

simply by being at the point of engagement with services, and each of the men appeared to have different reasons for engagement with services. For some, the hope of reconciliation with partners was a source of motivation. For others, gaining access to their children was paramount. However, common goals included forming and maintaining healthy relationships, securing and maintaining fulfilling employment, and building social networks. Although diversity of spirituality and cultural background appeared to contribute to the willingness to work toward certain goals such as relationship maintenance, all of the men did share the above goals in common.

This analysis of diversity and subjectivity helps to emphasise the importance of intensive engagement in services that are flexible to the needs of men as individuals, as well as a social group. Although identifying and understanding commonalities in experience helps to construct an approach to men's mental health service provision, understanding diversity can also help to make health interventions more effective (Courtenay 2000). This approach is consistent with contemporary approaches to gender relations including those based on feminist theory, as well as service provision to culturally and linguistically diverse groups (Courtenay 2000; Prasad-Ildes & Wright 2004).

6. The role of social support

For all their strength, men were sometimes like
little children.

Lawana Blackwell, *The Dowry of Miss Lydia Clark, 1999*

Discussion of the aforementioned emergent themes has highlighted the importance of a sense of belonging and worth to the men involved in this study. In addition to primary needs such as employment and housing, studies have shown the importance of social interaction through relationships to the health and wellbeing of both men and women (Lynch et al. 1998; Skarsater 2002). In order for men to negotiate hegemonic masculinity and remain socially connected, social support emerged as being of paramount importance. Despite this however, studies have also shown that not all forms of social support are useful for promoting wellbeing. The source of social support may be perceived positively or negatively based upon an individual's life experiences and current circumstances (Skarsater 2002). For many of the men involved in this study, existing social connections such as family and friends actually acted as sources of stress, thereby helping to maintain their situations.

The findings of this study emphasised the value of alternative forms of social support that provide men with a sense of acceptance and belonging. A number of the men discussed earlier found support groups to be very valuable in providing a space to share with other people who share common interests and life circumstances, e.g. AA & NA meetings, men's support groups, etc. In addition to the support and safety provided by counselling through Life Links, These groups helped to reduce social isolation and disconnection by providing an alternative life experience to rejection. This in turn, seemed to provide input into the men's social systems that changed the way they viewed their lived reality and therefore themselves (Zastrow 1997; Charon 1995). The case of 'Frank' (discussed earlier) helps to illustrate the importance of fresh social supports to providing normalisation.

Frank's family and work were proving to be sources of stress for him, however he described his attendance at Alcoholics Anonymous (AA) meetings as being a normalising experience. Frank attended AA with a work colleague and saw another long-standing work colleague at the meetings. This helped to show him that he was not on his own in relation to difficulties with alcohol and his life situation (Source: file CC501).

Interviews with workers also served to highlight the importance of acceptance of men who are going through problems that render them unable to fit into the norms of hegemonic masculinity. The following quote from 'PL02' in relation to what he feels is the required systemic response to men's mental health, helps to understand the important function of effective social support for men such as those in this study:

Just a big recognition that it is normal to feel depressed and that it's acceptable to get help. Those two messages...if we could get those two messages across, we'd be doing alright.

In a society where an adequate men's mental health system does not appear to exist, other social supports such as support groups, counselling, special interest groups, and social networks take on added importance in fulfilling the need to normalise men's mental health experiences.

Social systems theory emphasises the need for positive inputs into multiple systems, which interact to produce and maintain situations for individuals (Zastrow 1997). The cases of the men studied here show that in order to provide hope for the future, stability is required in the present. As discussed earlier, all of the men studied here were facing existential crises associated with adverse life circumstances, and the stress associated with traumatic change (Herman 2000; Lazarus 1984). In order to achieve the personal change

necessary to successfully renegotiate personal constructs of reality, the men first required stability in social circumstances. In addition to housing availability and employment opportunities, this stability appeared to be associated with connection to social supports, such as counselling, support groups, friends and family members. Group involvement may also act as a starting point for further engagement with services, (e.g. specialist counselling) from which men may be able to achieve successful reconstructions of their realities through various forms of emancipatory therapy, (e.g. Narrative Therapy, Dialectical Behaviour Therapy, etc.) (Wetchler 1996). All of the men involved in this study were able to access some level of social support due to the fact that their primary social needs were being met. Each man also showed some desire to change based on a reciprocal interaction between personal agency and social connection.

Conclusion

The major findings of this grounded theory study of men's mental health related to the following emergent themes:

1. The meaning of masculinity to the individual (core theme)
2. Social disconnection and exclusion
3. The 'situation-maintenance' cycle
4. The 'safe space'
5. Diversity and the subjective experience
6. The role of social support

These findings arose from secondary analysis of eight client case files, and semi-structured interviews with eight human service workers. Within these main themes it became apparent that men's experiences of masculinity related to all other emergent themes. Hegemonic masculinity requires men to conform to certain social norms of behaviour, such as control, rationality, heterosexuality, and breadwinner status (Connell 1995). When men are unable to fit into this hegemonic construction of masculinity and what it means to them, they are often labelled as deviant by society and left isolated from social institutions and relations (ed. Rabinow 1986). The men of this study were caught at the intersection of constructions of masculinity and mental health. The resulting 'double-bind' no-win situation appeared to contribute to both the creation and maintenance of these men's situations (Moller-Liemkuhler 2002). These men's experiences were characterised by stress cycles, depression, self-harming behaviours, service exclusion, relationship and family breakdown, unemployment, and social isolation. When examined closely, it became apparent that service systems are not set up to adequately deal with men's specific mental health concerns. In order to break 'situation maintenance' cycles, men need to be re-connected to social support within a safe space that suits their unique subjective needs.

The findings of this study appear to make a contribution to the development of theory relating to men's mental health. In addition, the findings point toward various recommendations related to service provision in the area of men's mental health. In relation to theory, the major findings of this research are:

- The Foucaultian double-bind created by constructions of masculinity and mental health, and its function of maintaining internal control over men's behaviour;
- The cyclical nature of men's depression, i.e. the relationship between antecedents to depression, depression itself, and the social response to depression, or;

- The compounding impact of social rejection on men's social disconnection and mental health;
- The human rights implications of diagnostic labelling and service exclusion;
- The 'cycle breaking' power of safety, social connection, and intensive service provision;
- The importance of the individual man's experience in the midst of shared social concerns (e.g. the interdependence of the individual's unique experience of life, and the shared experiences of a social group).

The major recommendations of this research are as follows:

- Increased State and Federal Government funding for larger-scale research into men's experiences of mental health;
- Further government funding of research into the impact of western hegemonic masculinity on Australian men. This would be aimed at contributing to a reconstruction of hegemonic masculinity, and a greater knowledge and promotion of alternative forms of masculinity;
- The development of a cohesive system of men's mental health service delivery involving both government and non-government agencies. One that also acknowledges and incorporates diversity, e.g. sexuality, cultural and linguistic, spiritual, etc.;
- The incorporation of a human rights discourse into service delivery to men with mental health concerns. This would be aimed at tempering the dominance of the biomedical and economic rationalist discourses of service delivery;
- Recognition of the need for intensive long-term public health funding, promotion and service provision for men;
- The further development of men's support programs and networks focussing on living with loss, trauma and change;
- The recognition and development of further government funded outreach services for homeless people due to the pressing reality serious mental health concerns and social exclusion;
- The extensive promotion of inclusive models of health service delivery to men, such as Centacare's Life Links for Men Project.

Reality is nothing but a collective hunch.

Lily Tomlin (1939 -)

References

- Alston, M. & Bowles, W. 2003, *Research for social workers: An introduction to methods 2nd edition*. Allen & Unwin, Crows Nest, Australia.
- Australian Bureau of Statistics, 1998, *Mental Health and Wellbeing: A Profile of Adults*. Australian Government Publication Service, Canberra.
- Australian Bureau of Statistics, 2003, *Suicide: Recent trends, Australia*. Cat. no. 3309.0.55.001. ABS, Canberra.
- Ball, R. 1997, Access to care by the disadvantaged. In *National Men's Health Conference (2nd: 1997: Fremantle, WA). Conference proceedings*, pp. 161–166. Australian Government Publishing Service, Canberra.
- Benner, P., & Wrubel, J. 1989, *The primacy of caring: stress and coping in health and illness*. Addison–Wesley Publishing Company, California.
- Bille–Brahe, U. 2000, Sociology and suicidal behaviour. In *The International Handbook of Suicide and Attempted Suicide*, eds. K. Hawton & Kees van Heeringen. John Wiley & Sons, West Sussex, England.
- Buhrich, N., Hodder, T. & Teesson, M. 2000, Lifetime prevalence of trauma among homeless in Sydney. *Australian and New Zealand Journal of Psychiatry*, 34, pp. 963–966.
- Cantor, C.H. 2000, Suicide in the western world. In *The International Handbook of Suicide and Attempted Suicide*, eds. K. Hawton & Kees van Heeringen. John Wiley & Sons, West Sussex, England.
- Charon, J.M., 1995, *Symbolic interactionism: and introduction, an interpretation, an integration*. 5th edn. Prentice–Hall, New Jersey.
- Commonwealth Department of Health and Aged Care, 2000, *National Action Plan for Depression*. Mental Health and Special Programs Branch, Canberra.
- Connell, R.W. 1995, *Masculinities*. Polity Press, Cambridge, U.K.
- Connell, R.W. 1998, Men's health: Healthcare policy is beginning to recognise issues of masculinity. *Medical Journal of Australia*, 169, pp. 195–196.

- Conway, J. 2001, An Australian perspective on international fields of practice in social work. In *Social work: fields of practice*, eds. M. Alston & J. McKinnon. Oxford University Press, South Melbourne.
- Cooper, L.A, Brown, C., Vu, H., Ford, D.E & Powe, N.R. 2001, How important is intrinsic spirituality in depression care? A comparison of white and African American primary care patients. *Journal of General Internal Medicine*, 16, pp. 634–638.
- Courtenay. W.H. 2000, Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science and Medicine*, 50, pp. 1385–1401.
- Dear, K., Henderson, S. & Korten, A. 2002, A. Well-being in Australia: Findings from the National Survey of Mental Health and Well-Being. *Social Psychiatry Psychiatric Epidemiology*, 37, pp. 503–509.
- Deville, G. & Cotton, P. 2004, Caveat emptor, caveat venditor, and critical incident stress debriefing/management (CISD/M). *Australian Psychologist*, 39(1), pp. 35–40.
- Dey, I. 1999, *Grounding grounded theory: Guidelines for qualitative inquiry*. Academic Press, California.
- Donzelot, J. 1980, *The policing of families*. Hutchinson & Co., London.
- Fletcher, R. 1995, An outbreak of men's health – the history of a welcome epidemic. In *National Men's Health Conference: Proceedings, 10–11 August 1995*, pp. 26–31. Australian Government Publishing Service, Canberra.
- Fook, J. 1996, The reflective researcher: Developing a reflective approach to practice, in *The reflective researcher: social workers' theories of practice research*, ed. J Fook, Allen & Unwin, St Leonards, pp. 1–8.
- Foucault, M. 1984, Introduction. In *The Foucault reader*, ed. P. Rabinow. Pantheon Books, New York.
- Glaser, B.G. & Strauss, A.L. 1973, *The discovery of grounded theory: strategies for qualitative research*. Aldine, Chicago.
- Halkitis, P.N. 2001, An exploration of perceptions of masculinity among gay men living with HIV. *Journal of Men's Studies*, 9(3), pg. 413.

- Herman, J.L. 2001, *Trauma and recovery: from domestic abuse to political terror*. Pandora, London.
- Holliday, A. 2002, *Doing and writing qualitative research*. SAGE Publications, London.
- Ife, J.W. 1997, *Rethinking social work: towards critical practice*. Pearson Education Australia, Frenchs Forest, NSW.
- Ife, J.W. 2001, *Human rights and social work : towards rights-based practice*. Cambridge University Press, Oakleigh, Australia.
- Isaacson, G. & Rich, C.L. 2001, Regular review: Management of patients who deliberately self-harm themselves. *British Medical Journal*, 322, pp. 213–215.
- James, M. 1995, Private pain versus public shame. In *National Men's Health Conference: Proceedings, 10–11 August 1995*, pp. 126–130. Australian Government Publishing Service, Canberra.
- Jorm, A.F. 1995, Executive summary. In *Men and Mental Health*, ed. A.F Jorm. National Health and Medical Research Council: Canberra
- Lazarus, R.S. 1984, *Stress, appraisal, and coping*. Springer Publishing Company, New York.
- Levang, E. 1998, *When men grieve: why men grieve and how you can help*. Fairview Press, Minneapolis.
- Lynch, T.R., Mendelson, T., Robins, C.J., Krishnan, K.R.R., George, L.K., Johnson, C.S. & Blazer, D.G. 1998, Perceived social support amongst depressed elderly, middle-aged, and young adult samples: cross-sectional and longitudinal analyses. *Journal of Affective Disorders*, 55, pp. 159–170.
- McFarlane, A.C. 2000, Traumatic stress in the 21st century. *Australian and New Zealand Journal of Psychiatry*, 34, pp. 896–902.
- Moller-Liemkuhler, A. 2002, The gender gap in suicide and premature death or: Why are men so vulnerable? *European Archives Psychiatry Clinical Neuroscience*, 253, pp. 1–8
- Palmer, S., Stalker, C., Gadbois, S. & Harper, K. 2004, What works for survivors of childhood abuse: Learning from participants in an inpatient treatment program. *American Journal of Orthopsychiatry*, 74(2), pp. 112–121.

- Parslow, R.A. & Jorm, A.F. 2000, Who uses mental health services in Australia? An analysis of data from the National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry*, 34, pp. 997–1008.
- Payne, M.S. 1997, *Modern social work theory*. 2nd edn. Lyceum Books, Chicago.
- Prasad-Ildes, R. & Wright, B. 2004, *One size does not fit all: the case of standardised mental health outcome measures in multicultural Australia*. Synergy 2004, No. 1, Multicultural Mental Health Australia, Parramatta.
- Real, T. 1997, *I don't want to talk about it: Overcoming the secret legacy of male depression*. Newleaf, Dublin.
- Russell, D. & Judd, F. 1999, Why are men killing themselves? A look at the evidence. *Australian Family Physician*, 28(8), pp. 791–795.
- Skarsater, I. 2002, *The importance of social support for men and women suffering from major depression: A comparative and explorative study*. The Sahlgrenska Academy, Goteborg, Sweden.
- Wadham, B., Bentley, M. & Booth, R. 1995, Strategic directions for men's health: therapy or reform? In *National Men's Health Conference: Proceedings, 10–11 August 1995*, pp. 213–220. Australian Government Publishing Service, Canberra.
- Weiss, R.S. 1985, Men and the family. *Family Process*, 24, pp. 49–58.
- Wetchler, J.L. 1996, Social constructionist family therapies. In *Family therapy sourcebook*, eds R.P. Peirce *et al.* 2nd edn. Guilford Press, New York, pp. 129–141.
- Wilton, R.D. 2003, Poverty and mental health: a qualitative study of residential care facility. *Community Mental Health Journal*, 39(2), pp. 139
- Zastrow, C. 1997, *Understanding human behaviour and the social environment*. 4th ed. Nelson–Hall, Chicago.

Appendix 1

November 12, 2004

Interviewee

Dear interviewee,

My name is Dilip Balu and I am a social work student from Charles Sturt University completing a research placement at Centacare Sydney on the Life Links for Men Project. I am engaged in a qualitative study of men and mental health. The purpose of this research is to explore men's experiences of mental health in the context of policy and service delivery in the Centacare Sydney area. This research is inductive in nature and therefore aims to form hypotheses relating to men's mental health as the research process unfolds. A secondary analysis of Life Links for Men client files is being conducted to help explore the life experiences of men with serious self harm issues, and interviews will be conducted with workers from several different agencies to gain information on men's mental health from a service delivery perspective. This study will utilise semi-structured interviews, and grounded theory to analyse data gathered.

I am hoping to interview you as part of this research with the aim of understanding men's mental health from a service delivery point of view. Your responses will help provide valuable information that will assist in furthering investigation into an area of health that has traditionally been under-investigated. Your participation in this study is completely voluntary, and the information you provide will be kept confidential. Although information will be collected relating to the nature of your interaction with male clients, this information will not be used to identify you or your agency, unless prior consent has been secured to do so. As an interviewee you will have the right to edit or amend content, withdraw your participation, or remain anonymous.

Please note that, should you have any complaints about the conduct of the research, you may contact the following people:

Stephen Kilkeary: Specialist Counsellor & Student Supervisor

Life Links for Men Project, Centacare Sydney on

Karen Bell: Charles Sturt University Practicum Liaison on

Any time you are able to give to participate in this interview process will be much appreciated. The interview should take around 30 minutes.

Please feel free to call me on, should you have any queries about the research. Otherwise, I will be in touch to organise a date, time and venue to conduct the interview.

Cheers,

Dilip Balu

Principal Researcher

Appendix 2

Research Project: Men's Experiences of Mental Health

Semi- structured interview schedule: For interviewee

1. How would you describe your work?

2. How long have you worked in this area?

3. What common themes emerge from your work with men?

4. Any other comments on the area of men's mental health?

Appendix 3

ASSESSMENT & CLINICAL OPTIONS for CLIENTS

where SELF-HARM is a SERIOUS CONCERN

**Consultation with and Referrals to the Specialist Counsellor*

INTRODUCTION

The Specialist Counsellor has been employed to work with men in the 25–44yo age group, where self-harm is a serious concern. He can, however, offer consultation on the topic of self-harm in whatever counselling context it might occur. Self-harm here is defined more broadly than it is for Intake Workers. It includes suicidal thoughts and actions, self-injury, self-mutilation and other forms of potentially life-limiting activities.

This document is divided into four parts:

1. Services Offered
2. Referral Guidelines
3. Self-Harm Checklist

1. SERVICES OFFERED

As this is a new role, the services offered by the Specialist Counsellor will be flexible according to demonstrated need. At this stage, the services offered include:

a. Case Consultation

Where you can discuss your Client's case with the Specialist Counsellor. This discussion would invariably focus on the subject of self-harm.

–On this basis, collaborative strategies for successfully working with the Client's self-harm issues might be developed.

b. Clinical Consultation

(i) Assessment

Where, for one or more sessions, the Specialist Counsellor can see your Client to assess their self-harm issues.

–This would, for example, allow the Specialist Counsellor to give you another perspective on your Client's case and perhaps, assist you in clarifying the Client's therapeutic and practical needs.

(ii) Review

Similar to the aforementioned procedure, however, in this instance the Specialist Counsellor sits in with both you and the Client and leads the session or sessions.

–This might be useful, for example, in working out where to take a case where self-harm issues have emerged as a clinical 'stumbling block'.

c. Referral

Made to the Specialist Counsellor after consultation with him, in cases where self-harm seems to be the core issue for the Client.

–Such referrals, depending upon the details of the case, might be unilateral, but could also involve referring the Client back to you if and when the self-harm issues are resolved.

**2. CLINICAL CONSULTATION
and REFERRAL GUIDELINES**

As the resources of the Specialist Counsellor are limited, there needs to be some criteria by which clinical consultations and referrals are enacted. Case consultation, of course, can occur informally and at any time, with respect to availability. For clinical consultation and referrals, the guidelines are as follows:

1. The Client is an adult male, preferably in the 25–44yo age group.
2. The Client's self-harm issues are of serious concern to you.
3. You have worked through the Self-Harm Checklist.
4. You have consulted with the Specialist Counsellor about the Client.
5. There are specific, identifiable outcomes that you wish to achieve.
6. The Client **must** have given his informed consent to see the Specialist Counsellor.

Appointments can be made for your Client and, where necessary, yourself as well to see the Specialist Counsellor on either an 'Urgent' or 'Routine' basis.

‘Urgent’ covers those situations where you believe that self-harm that might cause injury or death to the Client is highly likely but not imminent.

‘Routine’ covers any other situation where you believe that self-harm is a serious concern for the Client.

These categories are distinguished in the Appointment diary, under the Specialist Counsellor’s name, by the symbols (U) for Urgent and (R) for Routine.