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"You've Gotta Be That Tough Crust Exterior Man": Depression and Suicide in Rural-Based Men

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Abstract

Suicide rates in Canada are highest among rural men. Drawing on photovoice interviews with 13 women and two men living in a small rural Canadian town who lost a man to suicide, we inductively derived three themes to describe how contextual factors influence rural men's experiences of depression and responses to suicidal thoughts: (a) hiding depression and its cause, (b) manly self-medicating, and (c) mobilizing prevention. Further discussed is how gender relations and ideals of masculinity within rural milieu can inhibit men's acknowledgment of and help seeking for mental illness issues. Participants strongly endorsed a multifaceted approach to the destabilization of dominant ideals of masculinity that likely contribute to depression and suicide in rural men.

Keywords

men's health; masculinity; rural health; suicide; Interpretive description; Canada

In Canada, men account for four out of every five deaths by suicide (Statistics Canada, 2012), and suicide is the second leading cause of death for men 15 to 24 years old. While suicide has been linked to a variety of factors including substance use, history of trauma and family violence, sexual abuse, and distress related to sexual identity (Afif et al., 2008; MacKenzie et al., 2011), severe depression is the most powerful predictor of suicide behaviors and suicide (Gonzalez, 2008). In English-speaking Western countries, men's suicide rates are discordant with formal diagnoses of depression in men. Women are diagnosed with depression twice as often as men, but men die by suicide at 4 times the rate of women (Möller-Leimkuhler, 2003; Murphy, 1998).

The paradoxical relationship between men's depression and suicide has brought into focus the ways in which dominant ideals of masculinity are woven into the fabric of health care and social practices. Canetto and Sakinofsky (1998) described how cultural gendered scripts, wherein suicide is more expected for Western men than for women, have bearing on why deaths are reported (or not reported) as suicide. Some experts have also suggested that the lower reported rates of men's depression may be due to the widespread use of generic diagnostic criteria that are not sensitive to depression in men (Cochran & Rabinowitz, 2003; Kilmartin, 2005). Others have argued that masculine ideals of self-reliance and stoicism fuel men's reticence to seek professional help for fear of being seen as weak (Oliffe & Phillips, 2008).

Men's health has been theorized using the hegemonic masculinities framework first articulated by Connell (1995). Since then, however, analyses of the intersections between masculinities and health practices have been criticized for being reductive as they do not adequately account for a plurality of performances and embodiments (Messerschmidt, 2012) and do not fully conceptualize the influence of place and gender relations on men's health and illness practices (Philo, Parr, & Burns, 2003). As Sloan, Gough, and Conner (2010), Oliffe and Sarbit (2012), and others have established, there is no one set of idealized masculinities that men embody with respect to health or illness. Connell and Messerschmidt (2005) clarified further that local performances of masculinities should be understood as connecting to dominant patterns of masculinity that exist at the regional and global levels.

That said, rurality, even between settings which seem ethnically and racially homogeneous, can encompass diverse performances of masculinities. Brandth and Haugen (2005) advocated an analysis of rural masculinities sensitive to the dynamics of social spaces. Drawing on

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Connell's (1995) framework of contextually sensitive hegemonic masculinities, Peter, Bell, Jarnagin, and Bauer (2000) offered a model that anchors rural masculinity in the context of diverse rural settings. They, along with others (e.g., McLaren & Challis, 2009; Roy, Tremblay, Robertson, & Houle, 2015), noted that rural contexts with agricultural practices that are more individualistic and competitive (i.e., every farmer for himself) shape monologic masculinity, which is characterized by toughness, resilience, and a desire to be seen to confront danger and control the land. Other researchers have applied the model of rural monologic masculinity to communities with a focus on resource extraction such as forestry, oil and gas, and mining (Brandth & Haugen, 2005; Coen, Oliffe, Johnson, & Kelly, 2013; Little & Panelli, 2003). Morris (2008) showed how regional ideals and practices of masculinity extend to shape performances of masculinity in rural schools. Boys, for example, could only be assured of attaining masculine credentials through engagement in a limited number of activities including football or hockey.

Rural settings, as with all contexts, are immersed in dynamic systems of gender relations and are seeing the "increasing subtlety and fragmentation" of hegemonic ideals (Connell & Messerschmidt, 2005, p. 835). Environments with emphasis on more collective and cooperative farming tended to produce a more *dialogic* masculinity affording a range of performances including emotional openness and concerted efforts to garner success both in work and relationships. As Bye (2009) remarked, though rural men—particularly young men—are increasingly able to incorporate these "new" traits into family life, monologic masculinities prevail in the workplace and schools to limit the spaces and places where dialogic masculinities are performed (Bryant & Pini, 2011; Morris, 2008).

While the diagnosis and treatment of depression can reduce the potential for suicide (Wang, Angermeyer, Borges, Bruffaerts, & Chiu, 2007), rural men are less likely than urban men and women to access mental health services. Seeking medical help is unmanly (Mansfield & Addis, 2003) and policed (King, Land, & MaDougall Greenhill, 2009; Nicholson, 2008), wherein the underbelly of rural community cohesion can impose surveillance and stigma to *other*, those deemed different and/or deficient (Alston, 2012; Little & Panelli, 2003). The objective of this study was to describe the underpinnings of rural men's depression and suicide through analysis of participants' reflections on the event and aftermath of losing a male to suicide. Because survivors of a recent suicide are often deeply reflective about the conditions underpinning the death and uniquely positioned to offer insight into priorities for prevention, we undertook interviews with individuals who have lost a man in their life to suicide (White, 2015).

Method

The data that provide the basis of this article are drawn from a larger study addressing men, depression, and suicide in which we interviewed men and women who had lost men to suicide and men who had previously experienced suicidal behaviors. The project researchers were contacted by a female artist and community member in her 20s, who lobbied for the inclusion of the perspectives of rural-based people in an existing photovoice study addressing men's depression and suicide which, up until that point, had only included urban-based participants. The community member had lost her brother to suicide while growing up in a small Canadian town and felt strongly about the need to de-stigmatize men's depression and facilitate community talk and action toward preventing male suicide. Following university research ethics approval, the community member worked with researchers to identify potential research participants. As a condition of ethics, following an initial letter of introduction, the community member had no further contact with potential participants regarding the study and she did not have access to the research data collected.

The geography of Canada comprises approximately 95% rural and remote settings, and 30% of the population live in rural communities (Health Canada, 2008). The town in which we conducted the interviews had a population of 2,500 people and the main industries were farming and oil/gas extraction. Harsh winters and limited job options impacted the type and availability of paid work and recreational activities. Aside from a small number who identify as Aboriginal, the population of the town largely identified as Anglo-Canadian with English the only language spoken at home (Statistics Canada, 2006). The small community was close knit in that many people knew one another, and outsiders or visitors to the town could draw curiosity from the locals. While recruitment posters and online and local newspaper ads were used, 12 of the 15 participants volunteered after being contacted directly by the community member, confirming the importance of having authentic community engagement (DiBartolo & McCrone, 2003). Potential participants contacted the project manager, who determined eligibility for the study, explained the photovoice assignment, and detailed the process for being interviewed around the photographs that they had taken depicting their experiences of losing a man to suicide. Individual interviews were conducted by a female researcher with extensive training and experience in photovoice and rural men's health research.

Sample

Thirteen Anglo-Canadian women and two men who self-identified as heterosexual ranged in age from 23 to 71

years old ($M = 44.3$) and had lost a male to suicide 1 to 3 years prior, participated in the study. In contrast to the demographics of our broader sample, in which larger numbers of men than women participated, in this rural setting, we were unable to recruit more males who had lost men and previously suicidal men. This study reports on six male rural suicides from participant's perspectives whom had a broad set of relationships to the deceased including mothers ($n = 5$), sisters ($n = 3$), friend ($n = 2$), aunt ($n = 1$), daughter-in-law ($n = 1$), wife ($n = 1$), father ($n = 1$), and son ($n = 1$). The men lost to suicide lived in the small town or nearby and all but one of the men had died in late adolescence or in their early 20s. All had died by hanging which is the leading method of suicide for men between the ages of 15 and 39 years (Statistics Canada, 2013).

Data Collection

Using qualitative methods, to help better contextualize men's depression and suicide (Han & Oliffe, 2015), the researcher individually interviewed 15 participants. We used photovoice methods to capture rich and nuanced descriptions of the loss of a man to suicide and to ease the potential discomfort of talking about the event and the aftermath (Clark-Ibanez, 2004; Drew, Duncan, & Sawyer, 2010; Keller, Fleury, Perez, Ainsworth, & Vaughan, 2008; Kohon & Carder, 2014; Packard, 2008). We also used photovoice methods as they have been shown to be an effective strategy to garner conversations in the third person and distance the participant from direct question–answer approaches used in some qualitative interviews (Oliffe, 2007).

Participants were emailed an information sheet and a consent form 1 week prior to the interview. During the first meeting, participants were guided through a process of informed consent and offered a digital camera (which they could keep as an honorarium) to take photographs depicting their experience of losing a man to suicide. If participants chose to use their own camera, they were given US$100 honorarium as a thank you for participating. Participants submitted between four and 29 photos ($M = 11$) and on receipt of the photographs, the researcher scheduled an individual interview. All the participants were provided a mental health care resource list ahead of commencing the interview. The interviews lasted between 1 and 2 hours and focused on the participant's experience and reflections on losing a male to suicide. The interview included questions such as the following: "Describe your relationship to the man who died," "What signs might have indicated he was at risk of suicide?" "What do you believe may have led to the suicide?" Also explored were how gender, sexuality, mental illness, and living in a rural community might have impeded or facilitated seeking support. When discussing the photographs, the interview was participant driven with the interviewer providing occasional prompt questions such as "Tell me what this picture is about," "What was the inspiration for this image?" "Tell me more about why you decided to take this picture."

The interviews were digitally recorded. Immediately following the interviews, these recordings and participant-produced photographs were password protected and downloaded to a secure server. Interviews were transcribed verbatim and checked for accuracy, and the corresponding photographs were inserted to the interview text. Ahead of being uploaded to Nçιтσo™, details potentially identifying participants and/or the deceased were deleted. Pseudonyms were assigned by the researchers to ensure anonymity.

Data Analysis

The objective of this study was to describe the underpinnings of rural men's depression and suicide through analysis of participants' reflections on the event and aftermath of losing a male to suicide. Data analysis was led by the female researcher who conducted the interviews and a male principal investigator for the broader study. For the purpose of analysis, we used interpretive descriptive methods (Thorne, 2008) drawing on constant comparative techniques synonymous with grounded theory. Consistent also with a grounded theory approach, data analysis was concurrent with data collection. The interviews were read independently by the Drs. Creighton and Oliffe to inductively derive a coding schedule to make broad fractures to the data. After several meetings, agreement was reached on the codes which included factors underlying men's depression and suicide, reactions to the news of the suicide, and suggestions for male suicide prevention. The researchers read through the interview data line by line, and coded data to the aforementioned broad codes (Boeije, 2002; Dey, 1999; Strauss & Corbin, 1998). Using this analytical frame, the researchers distilled preliminary insights about patterns and diversity within and across the participants' coded data.

Tentative labels were developed for the findings derived from each of the codes, and consensus about the results was reached through discussions among the researchers. In keeping with interpretive descriptive methods, three inductively and deductively derived themes—(1) hiding depression and its cause, (b) manly self-medicating, and (c) mobilizing prevention—were developed, and included in the results are illustrative participant quotes. To theorize the findings, place (Massey, 1994) and gender (Connell, 1995) frameworks were drawn upon to add to the existing scholarship addressing rural men's health and masculinities (Campbell, 2000;

Coen et al., 2013; Roy et al., 2015). As the photographs were used primarily as a vehicle to develop and expand upon participant narratives, the images are not presented in the current article.

Results

Hiding Depression and Its Cause

Most participants spoke about stigma in mental illness and suggested that the men lost to suicide may have thought that revealing their depression would be interpreted by others as weakness. Lena's 23-year-old son Quinn died after he hung himself from a tree in a nearby ravine. She had long suspected that he suffered from depression, but any effort on her part to discuss his well-being and the worth of accessing professional supports was met with forbearance. Lena suggested that, while part of Quinn's reluctance to address his depression was modeled on his father's self-reliance, she argued that Quinn's desire to be stoic was shaped by wider institutional masculine norms synonymous with the province's oil and gas industries. As he was a young boy, Quinn wanted to be a welder:

> He had dollar signs in his eyes. In [the region], it's a big deal—lots of money, and you know, they're selling the dream to the young men in particular, the "make the money" dream. They came to his high school when he was in—just into grade 10 and gave a big presentation and you could start welding in high school as well as doing your schooling.

Lena spoke about the remoteness and often "brutal" work condition in the oil fields and how workers were isolated from friends and family for long periods of time, "He would work incredibly long hours and days and days in a row and then come back for a break so dirty and tired that he was almost unrecognizable." According to Lena, the workplace demanded unwavering grit mustering the need to internalize and push through the physical and emotional pain without complaint. Quinn's younger sister Bailey described the change that came over him the longer he worked remotely, going from being a sensitive, artistic adolescent to a tough young man. She recalled a critical incident that served to shape her brother's emergent persona. He had been welding while lying on his back when liquid metal fell onto his abdomen. While he was writhing in pain, his boss laughed at him and told him to "suck it up." "I think from there, it was like he just started to harden up."

Noah hung himself in the back shed that he and his father had built the summer prior 3 weeks after his 17th birthday. His parents and sisters described him as an athletic, accomplished, kind teenager who loved soccer and hanging out with friends and family. His mother Diane described his death as coming "out of the blue" and agonized over the signs she felt she must have missed. Only his suicide note revealed his long-standing depression and emotional pain.

> He must have been in such terrible pain, but he never let on. I don't know if he wanted to spare us having to deal with something that he thought was unsolvable or he just didn't think there was anything anyone could do to help. I wish he would have let us hear him.

While Quinn's family had some knowledge that he was struggling with mental illness, Noah's family and friends were taken by surprise. Noah concealed his depression while achieving much in his short life: the captain of his rural school and community sports teams and the recipient of academic awards. His sister and mother both wondered whether Noah might have avoided discussing his feelings of unhappiness for fear that such disclosure would estrange him from family and friends. As his sister stated, "He was just such a golden boy—that was how everyone saw him. There was no way that anyone would have thought there was anything going on and he probably wouldn't have known how to start the conversation."

In terms of the cause or underpinnings of depression, several participants wondered whether a struggle with sexual identity was a trigger for the men who had died. Confirming other research (e.g., Gottschalk & Newton, 2009; Saewyc, Poon, Wang, Homma, & Smith, 2007), participants highlighted the ever-present pressure to fit in to a heterosexual model as characterizing their rural context. Lindsay, a close friend of Diane, reflected on how this may have impacted on Noah. While she had no knowledge that Noah might have been struggling with sexual identity himself, she did observe that, if he had been, it would likely have been difficult to express himself:

> I think there are so many reasons for suicide right? We can't peg that down, but I think that you know if [a man] has a sexuality issue or a gender issue in a rural area there's hardly any outlets and huge stigma, huge. Also, men who have not seen the world, this is their world and it is so small.

Following Quinn's death, a friend of his told Lena (Quinn's mother) that on one occasion, when Quinn was drinking heavily, he had blurted out that he was gay. While Lena considered her family to be very open minded about issues of sexuality, she understood that it would not have been acceptable in what she referred to as a "super masculine" environment at his place of work, "if sexuality was an issue for him, the homophobia within the trades is so gross and the homophobic jokes are so gross." Lena perceived that her son may have experienced some self-hatred and may have been afraid of the hostility he would have encountered if he were gay and had come out.

Jennifer, a physician in the small town, attended the deaths of two male suicides in the community, both Noah's and a 19-year-old man, Ethan. When reflecting on these suicides, she too observed the narrowness of acceptable behaviors made available to young men in the community. She confirmed that young men who were gay or simply did not identify with the expressions of masculinity dominant within the community had few options for alternative activities. Referring to a short-lived amateur theater group in the town, she spoke of the way that initiatives that may have supported alternative expressions of masculinity quickly died out, "You have to be a pretty brave soul to get up on stage and act though, when all your buddies are out drinking. You may as well put a big sign on your head that says 'I'm homosexual.'"

Participants were in strong agreement that community norms that upheld performances of heterosexual masculinity discouraged men from talking about feelings of sadness, depression, and/or vulnerability. There were perceptions that men who may have been struggling with issues of sexual orientation stayed especially silent and hidden to avoid social stigma.

Manly Self-Medicating

Rural communities typically have few mental health resources and services (Canadian Institute for Health Information, 2006; Nicholson, 2008). In addition, participants noted that it was difficult to access professional help confidentially. Men tend to use other strategies aligning to masculine ideals such as self-medicating with drugs and alcohol, attempting to "overpower" their depression, or engaging in risk taking, violence, and aggression (Brownhill, Wilheim, Barclay, & Schmied, 2005; Emslie, Ridge, Ziebland, & Hunt, 2006). Because these actions reside outside traditional markers associated with depression, such as low mood, apparent sadness, and excessive sleep, men's suicide can emerge as unexpected and shocking to friends, family, and partners.

Laurie's father-in-law, Ben, age 58, suffered from depression prior to his suicide. He hung himself in his cabin, the small structure outside of the rural town in which he spent most of his time alone. When he did visit, instead of enjoying time interacting with his children and grandchildren, he would spend hours at the computer. Laurie described the way that Ben attempted to remedy his depression through physical means:

> [He was thinking] he could fix everything from a physical standpoint. He was very athletic, he was all about having the right vitamins and supplements and he was never a drinker, never a smoker or anything like that, so—no coffee, very focused on that physical health.

She contended that it was as if Ben believed that if he just found the right supplement, his depression would lift. With no local community resources, he refused to reach out for the help of his son and expressed anger toward his family and partner. As Laurie reported, "he was rigid and judgmental and just pushed everyone away."

Lena and Bailey both described Quinn's growing use of drugs and alcohol and reflected that this may have been an attempt to dampen his pain. Bailey recalled that her brother started smoking marijuana at 14 or 15, and progressed to doing methamphetamine and cocaine on a regular basis. By the time he was 21, he had moved out and was working 60 to 65 hours per week as a welder and, when he was not working, he was partying. Lena attributed Quinn's use of hard drugs, at least in part, to his workplace where many men used cocaine, not only to sustain their long hours of hard labor but also because it flushed out of the system more quickly than marijuana. Bailey viewed Quinn's drug use as a form of self-medication in which he was attempting to banish his negative thoughts:

> He was super caught up in this cyclical, dark place that he was in, and I think that the addiction was a big part of it, but I also think that he had some pretty crazy demons for a pretty long time. I'm not sure how long he would have struggled with that, but I would almost say maybe it was almost 10 years.

Noah's family wondered if his intense involvement in sports represented more than just a love of soccer and basketball. When his sister had disclosed her depression to her parents, they had instructed her to get more exercise and perhaps he had heard and heeded this advice, persisting with it, though ultimately it did not help. As his sister stated,

> He was majorly into sports so he played competitive soccer on 4 teams. And he was playing football, he was doing all these things and I remember telling him I thought he was doing too much and he was like "oh it's only for 6 weeks." For lots of things I look back on now and I think maybe he was just trying to keep himself so busy because he was having a really hard time.

It is possible that Noah's strategy for dealing with his depression was to literally and figuratively outrun it. Unlike Quinn's overuse of drugs and alcohol, which some friends and family members in hindsight perceived to be maladaptive, Noah's involvement in sports was seen as laudable. The "demons" that Noah fought silently proved to be more powerful. Regardless of the means they chose, participants perceived that men attempted to deal with feelings of depression on their own rather than risk being seen as vulnerable and weak through seeking professional help.

Mobilizing Prevention

Across the interviews, participants were passionate about the need to engage in prevention work to reduce male suicide. Ideas for prevention centered on breaking stereotypes about masculinity in families and communities, increasing dialogue about men's mental illness to reduce the stigma, and strengthening conversations about hope.

After her brother Noah died, his sister Taren remembered both of her parents articulating regret about not creating a home in which dark feelings or failure were openly discussed. They wondered had they shared their own experiences of challenges in adolescence and their early 20s, whether it would have quelled their son's anxieties about not measuring up. Strong in Taren's memory was her father's regret that he had not modeled a masculinity inclusive of vulnerability, sensitivity, and a willingness to turn to others for help:

> I know in the immediate aftermath and for months after, he [father] kept having the same conversation over and over again which was, "I wish that I had shown him how to be vulnerable," or "It's okay to be vulnerable." That being a man isn't about being strong and unaffected. I just remember my dad and all of these male friends who would come over and they're these callous-handed farmers and, they would just go for walks or sit in their living room and just weep.

Diane (Noah's mother) and Lena (Quinn's mother) spoke about how many rural-based people, family, and friends had come forward to talk about their own experiences with mental illness and depression following their teenage sons' suicide. Both women expressed frustration about the secretiveness surrounding mental illness. Lena speculated that if her family had been more forthcoming about the prevalence of bipolar disease among close relatives, she might have been better equipped to help her son:

> I talked about how it was so important for people to be honest. I mean we'd been totally honest the whole time and that you needed to remove the stigma and get the word out and just talk about it and make everybody aware of how much depression is really out there.

Diane also spoke about the frequency with which she observed people concealing their anxiety and depression amid widespread willingness to tell others that they were suffering from other medical conditions such as high blood pressure. She wondered whether highlighting that depression often had a biological basis could help to remove barriers to individuals getting help and reducing moral judgments about whether or not a person was authentic in their experiences of depressive symptoms.

> I think the biological nature of depression should be talked about more. You have to manage it like you would diabetes. Like think of it as a brain illness and you manage it with medication and behavior. "No one says, 'How could you have diabetes?' You're so blessed, you're so lucky, you're so loved.'"

Several participants spoke about the need within their rural community to emphasize interdependencies and the value of cooperation rather than reproducing and revering the value of independence. Jennifer spoke of the damage,

> Maybe that's part of that sort of rural Alberta kind of "You've gotta make it on your own," right? Always, "You gotta be tough, if you're not tough you don't deserve to be here"—that kind of mentality that only the tough survive . . . you can't depend on anybody.

Jennifer argued that there is a need to support young people through giving them tools and strategies rather than thrusting them into the outside world to sink or swim on their own.

Rather than solely focusing on what may have prevented the suicide of the man they knew, participants discussed the broader societal- and community-level changes needed to protect young rural men from self-harm. Suicide prevention efforts, in this regard, linked dominant ideals of masculinity to mental illness in arguing the value of modeling vulnerability and openness rather than stalwart stoicism.

Discussion and Conclusion

The findings drawn from the current study provide compelling evidence that place-based hegemonic ideals represented as monologic masculinities in rural contexts can exert significant pressure on rural men. Evident in the interviews were participants' perception of men's struggle to conceal divergence toward dialectic masculinities through secretly harboring depression and/or "alternate" gendered practices or sexual identities. Some stayed the monologic course through stoicism, distracting others, and in some cases one's self, from these taxing external and internal struggles. Illustrating diverse masculinities, some men likely used drugs and alcohol as a means to temporarily escape the pressures to be stoic about mental health issues rather than seek outside supports. The findings drawn from this research are discussed with a view to strengthening tailored efforts for preventing rural men's suicide.

Research has shown that overall, men, not only rural men, are less likely than women to seek formal and informal mental health supports (Addis & Mahalik, 2003; Oliffe & Phillips, 2008; Schofield & Connell, 2000). So

strong were the enforcements of these dominant place-based masculine discursive practices that conversations about depression in rural men were even more strongly muted. As Coen et al. (2013) argued, masculine strength needs to be reimaged to emancipate rural men to confront their depression and actively lobby assistance rather than ending their lives. As Roy et al. (2015) suggested, rural men's tendency toward optimism and endurance has the potential to be mobilized toward active coping rather than denial and silence. Of course, clearly, this is easier said than done. Modeling, affirming, and invoking men's stoicism and self-reliance were the agency of influential individuals and powerful collectives. Moreover, the governing structures, including those reifying what counts as manly rural work in the natural resources residing in and around the small town, beckoned men to "do" gender in stereotypical ways. These dominions were especially evident to participants, as were their recognition and reflections that the men lost to suicide had grappled with both the expectations and the limitations that defined and anchored ideals about rural men.

In terms of potential remedies, there was strong support for garnering community efforts to de-stigmatize mental illness. The lack of rural-based mental health services is especially problematic in this context, both because there are few options for men to access services anonymously and the absence of local specialty services implied that issues such as depression were rare in the small town and perhaps inconsequential. Even when counseling services are available, men are traditionally less likely to access them (Addis & Mahalik, 2003). In a similar vein, as participants reported, communities that are shaped by the oil and gas industry are strongly influenced by ideals of stoicism and invincibility and are characterized by homophobic and misogynistic attitudes (Shoveller, Goldenberg, Koehoorn, & Ostry, 2007). Isolation, harsh working conditions, long hours, and clustered shifts coupled with ostracism from direct family supports have a negative influence on health (Michie & Williams, 2003; van der Hulst, 2003) and can render men susceptible to drug and alcohol misuse and addiction (Goldenberg, Shoveller, Korhoorn, & Ostry, 2010). In the midst of industry-specific economic growth, much of which runs counter to the widespread global economic uncertainty, there remains little acknowledgment, let alone explicit prevention and treatment programs targeting men who, as a by-product of doing that demanding work, are at high risk of depression and suicide. There is a strong need for resource industries in rural areas to intervene locally to reduce the stigma surrounding mental illness by providing tangible services. Of course, mental health services should also be community driven and responsive to the economic drivers within rural settings. With this in mind, rural towns with strong resource extraction and/or agricultural industries would benefit significantly from community and workplace health services to address the mental health issues and substance use support groups for rural-based men and their families (Oliffe & Han, 2013).

Many participants reflected on the lack of resources and social acceptance for young men struggling with issues of gender and sexual identity and advocated the need for interventions. Secondary schools would likely provide effective insertion points for such programs. For example, there is evidence to suggest that schools that support gay–straight alliances (GSAs) have fewer suicides and suicide attempts among gay and lesbian students (Hatzenbuehler, 2011). GSAs have also been shown to reduce the risk of illicit and prescription drug misuse among sexual minority students (Heck et al., 2014). In addition, GSAs have been shown to reduce suicide and suicidal ideation among "mostly heterosexual girls and exclusively heterosexual boys" (Saewyc, Konishi, Rose, & Homma, 2014, p. 90), a finding confirming the potential of such initiatives to reduce stress and discrimination for all students. As Pascoe (2011) reminded us that homophobic environments put all men, not only those who identify as gay, under pressure to persistently "prove" their heterosexuality, in many cases by committing misogynistic acts, engaging in risk taking, and bullying others. While the number of GSAs, as well as more gender/sexuality sensitive mental health supports for students, are slowly increasing across Canada, their integration to rural settings has been especially challenging (Calgary Sexual Health Centre, 2016; Saewyc et al., 2014; Saewyc et al., 2007; School-Based Mental Health and Substance Abuse Consortium, 2013).

The narratives shared in the current study also work to challenge the psychiatrization of suicide and cause–effect assertions about mental illness. Indeed, the findings confirm the "problem" of male suicide as residing outside individual psychopathology strongly influenced by locale-specific community values which can govern gender practices. In addition, engaging communities to end silences around hegemonic masculine practices, which are associated with suicide, are likely crucial for preventing rural-based men's suicide. The willingness of participants to talk about their experiences of losing a man to suicide underscores the importance of facilitating such discussions and highlights the importance of health care service engagement with family, friends, and community members as a means to collectively do the work of suicide prevention. As consistently illustrated in participant interviews, individuals who have lost a loved one to suicide can be deeply reflective about the conditions underpinning the death and regrets about being complicit in their silence regarding the costs of hegemonic practices. In the period following a suicide, survivors are uniquely

positioned and motivated to challenge the local ideals and practices of masculinity, advocate to de-stigmatize mental illness, and lobby for effectual community-based depression services and suicide prevention programs.

A limitation of the current study resides in the homogeneity of the participants, most of whom were Anglo-Canadian women who had lost an Anglo-Canadian man or men to suicide. Although a range of recruitment efforts were used to include more male participants, we had few responses from men. This might be understood as reflecting the power of some masculine ideals to silence men. In turn, the current study findings are gendered—wherein primarily, women's understandings are forthcoming and openly shared. In sum, the proportionately large number of women in the current study mirrors our findings—many men are reticent to talk about male depression and suicide.

The gendered nature of the rural sample and, thus, our findings points to a larger limitation within suicide research and prevention work. By having a female local team member partnered with a female researcher doing rural interviews, we may have inadvertently reproduced norms wherein mental health/illness and suicide prevention is primarily a concern for women (Addis & Mahalik, 2003). While it is important to include women in efforts to intervene in men's depression and suicide, it is crucial to avoid placing, on women, the burden of men's care, thereby heightening their sense of guilt and regret (Bottorff, Oliffe, Kelly, Johnson, & Carey, 2014). While men are well represented in the upper echelons of leadership, there needs to be greater numbers of males working the frontline of mental illness research and service provision. From a community perspective, we need to find ways of having men engage the conversation of mental health and illness—to offer perspectives on their own experiences, to provide direction, and to give other men the permission to speak up about their concerns.

In conclusion, while the high male suicide rate continues to blight the peaceful image of the rural idyll, there is reason to hope that community movements can de-stigmatize men's depression. Reflections of participants demonstrated that there is both insight into the complex problem of male suicide and also commitment to address it at a multitude of levels. As such, the current study's findings serve as a call to action to this small town and other vulnerable rural communities to intervene to address and reduce men's depression and suicide.

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