Current Psychiatry Reports (2019) 21: 103
https://doi.org/10.1007/s11920-019-1088-y

SEX AND GENDER ISSUES IN BEHAVIORAL HEALTH (CN EPPERSON AND L HANTSOO, SECTION EDITORS)

Men's Depression and Suicide

John L. Oliffe[1] · Emma Rossnagel[1] · Zac E. Seidler[2] · David Kealy[3] · John S. Ogrodniczuk[3] · Simon M. Rice[4]

Published online: 14 September 2019
© Springer Science+Business Media, LLC, part of Springer Nature 2019

Abstract

Purpose of Review To explore recent research evidence addressing men's depression and suicide. Included are discussions of recent literature investigating male depression symptoms, and men's depression and suicidality help-seeking and engagement with professional mental health care services.

Recent Findings Specific externalizing symptoms of substance misuse, risk-taking, and poor impulse control among men indicate the need for gender-sensitized depression screening and risk assessments. The reticence of some men for seeking professional health care has drawn public awareness raising and de-stigmatizing efforts, while clinical guidelines for working with boys and men have been offered to better serve men seeking help for depression and/or suicidality.

Summary There is a strengthening case for male depression comprising specific externalizing symptomology, and these findings, along with high male suicide rates (including men who are seemingly in care), indicate the need for tailored approaches to men's depression and suicide prevention.

Keywords Male depression · Externalizing depressive symptoms · Men's suicidality · Men's mental health help-seeking

Introduction

Claiming the lives of boys' and men across all age groups, male suicide, and by extension male depression, is a significant global health issue [1]. Depression and suicide sex differences research has highlighted important patterns and diversity, including higher rates of diagnosed depression in women, and male suicide rates that are three times that of females [2]. To more fully understand and effectively respond to this public health problem, a range of approaches, including gender analyses, have been used to elaborate on men's (and women's) depression and suicide [3]. The key intent of the work focused on men's depression and suicide risk has been to advance the development and implementation of tailored clinical services to promote mental health and ultimately reduce male suicide [4]. In line with this, the current review focuses on men's depression and suicide, exploring the extant research to suggest some ways forward for the field to continue promoting the mental health of men. In linking male depression and suicide here, it is key to note that we are not espousing depression as the only route to suicide; instead, we offer a review of two deeply entwined issues to better understand and address the discordant relationship between men's low rates of formally diagnosed depression and high rates of suicide [5•]. Specifically, the current review discusses recent literature addressing the following: (1) the case for male depression as a distinct clinical phenotype and (2) men's help-seeking and engagement with professional mental health care.

This article is part of the Topical Collection on *Sex and Gender Issues in Behavioral Health*

✉ John L. Oliffe
john.oliffe@ubc.ca

[1] School of Nursing, University of British Columbia, Vancouver, Canada

[2] School of Psychology, The University of Sydney, Sydney, New South Wales, Australia

[3] Department of Psychiatry, University of British Columbia, Vancouver, Canada

[4] Orygen, The National Centre of Excellence in Youth Mental Health, Centre for Youth, Mental Health, The University of Melbourne, Melbourne, Australia

The Case for Male Depression as a Distinct Clinical Phenotype

Findings across Western and non-Western countries that women are diagnosed with depression twice as often as men have given rise to sex differences research and gender analyses aiming to more fully interrogate and address this widely

reported finding [6]. One long-standing hypothesis, originating in the work of Rutz and colleagues [7], is that some men's expression of depression is characterized by symptoms that are not captured by diagnostic criteria and commonly used clinical depression screening tools. The net result of this is that depression in men is missed or mis-diagnosed—and by extension undertreated by practitioners [8, 9••]. The diagnostic criteria for major depressive disorder focus on symptoms including sadness, anhedonia, and worthlessness among somatic domains of sleep and appetite disturbance. While these symptom clusters accurately reflect the experience of depression for many men, a broader conceptualization may also be required [10, 11]. In an attempt to clarify this distinction in symptomatology, researchers have identified a range of externalizing symptoms that differentiate a phenotypic variant of male depression. While conceding these externalizing symptoms may exist within and across an array of mood and other disorders, over the last two decades, studies have consistently indicated, albeit in varying configurations and constructs, that men experiencing depression are more likely than women to exhibit symptoms of irritability, anger, substance misuse, risk-taking, impulsivity, and over involvement in work [8, 11, 12, 13, 14•]. Moreover, these externalizing symptoms of male depression are also risk factors for suicide [15]. Within this literature, the much cited Martin et al.'s [9••] sex differences study, drawn from a nationally representative US sample, narrowed externalizing male depressive symptoms to anger attacks/aggression, substance misuse, and risk-taking while acknowledging that men were also likely to endorse many traditional depression symptoms. A systematic review and meta-analysis of 32 studies comprising a total of 108,260 participants synthesized work addressing sex differences in men and women with depression [14•], confirming that men with depression reported substance misuse, risk-taking, and poor impulse control more often, and with more intensity, than women with depression.

A number of tools have been developed to more thoroughly evaluate externalizing symptoms of male depression. The Gotland Male Depression Scale (GMDS; [13]) was the first of its kind, including a range of externalizing and prototypic symptoms. The GMDS has been criticized for its unreliable factor structure and inconsistent results [16]. Subsequently, the Masculine Depression Scale (MDS; [17]) was developed, but was also critiqued for a two-dimensional structure, leading to the more recent development of the Male Depression Risk Scale (MDRS) in an effort to address previous psychometric limitations [12]. Initial construct validity studies of the MDRS support its use [15], with the MDRS demonstrating structural stability, stable correlation with prototypic measures of depression (i.e., PHQ-9; [18]), and reliable differences between the sexes and test-retest validity within individuals [12, 19•]. The MDRS comprises six externalizing depression symptom domains: (1) emotion suppression, (2) drug use, (3) alcohol use, (4) anger and aggression, (5) somatic symptoms, and (6) risk-taking via self-report (relative to the preceding month). Originally developed in Australia, the MDRS was re-validated in a nationally representative Canadian male sample and found to have sensitivity relative to the PHQ-9 in identifying men with a recent suicide attempt [20•]. This finding built on previous research reporting that men with an externalizing depression symptom profile were significantly more likely to have had a recent suicide plan or attempt [21]. Comparing by age, younger Canadian men (18–25 years) reported markedly higher suicidal ideation in the context of externalizing symptoms of depression compared with older men [20•].

Taken together, empirical findings that suggest externalizing symptoms may be a particular phenotypic feature of depression in men have grown significantly, as have assertions lobbying clinical attention to screening for externalizing symptoms among men in conjunction with current "gold standard" self-report scales for assessing prototypic depression (i.e., the PHQ-9). As the field of study into male depression continues to evolve, future studies will address unresolved issues related to the phenomenology and assessment of depression in men. Cavanagh et al. [14•] and others [8, 12] have not argued for adjustments to established prototypic clinical tools used to diagnose depression in males. Instead, the case for male depression has focused on establishing the clinical relevance of externalizing depressive symptoms and associations with suicidality, proffering the potential of this work to advance clinical efficiencies for better identifying men at risk.

Researchers have theorized that driving these externalizing symptoms of depression are men's alignments to masculine norms, the socially prescribed rules for how a man *should* behave [17, 22]. Supporting this, Rice and colleagues [12] reported an interaction between sex (male/female) and conformity to masculine norm categories for externalizing depression symptoms, but not for prototypic symptoms assessed by the PHQ-9, indicating a gender effect for externalizing symptoms but not for prototypic symptoms. Genuchi and Mitsunaga [23] used the MDS to highlight college men as more often exhibiting externalized depressive symptoms when compared with college women. Asserted here was that men's experiences and expressions of a distinct externalizing set of symptoms were influenced by their alignment to masculine norms [23]. Genuchi and Valdez [24] also examined how adherence to masculine gender role norms and anger predicted depressive symptoms in college men, reporting that trait anger moderately predicted depressive symptoms; however, no masculine norms were associated with male students' endorsement of depressive symptoms. Some qualitative work has explored the differences between men's diverse expressions of masculinity (known as masculinities) and offered inductively derived insights for why anger, substance misuse, and self-isolating practices might pass as typical masculine

behaviors—rather than be indicative of, and formally evaluated as depressive symptoms. Specifically, men's alignment to idealized masculinities that condone the expression of anger, substance misuse, and solitary pursuits as every day manly practices is purported to mask internalizing depressive symptoms [25] and suicidality [26]. In summary, the case for male depression continues to be finessed but is increasingly supported by population studies and meta-analytic work [9••, 14•].

Men's Help-Seeking and Engagement with Professional Mental Health Care

Widely reported in the literature is men's reticence for seeking professional mental health care [27] and sex differences wherein males comprise only a third of those seeking help for mental health concerns [28]. However, in the context of depression and suicidality, there is much diversity in men's help-seeking and their engagement with professional mental health care. While many men lack insight or disavow depressive symptoms or suicide risk, in turn denying the need for professional help [27], up to 60% of men who die by suicide have accessed health care services in the year prior to their death [29]. This contrast, often positioned as a binary (i.e., men refusing care versus men in care), operates across a continuum of refusing care, being in care, and being lost to follow-up (between care). Two distinct bodies of work preside to explain men's mental health help-seeking. The first has focused on describing factors influencing men's resistance to seeking professional mental health care. A second, somewhat emergent literature has begun to investigate men's engagement with professional mental health care to better understand what works clinically, as well as what adjustments might reduce the number of men "lost to follow-up" and those who suicide despite seemingly being "in care."

The work describing men's reticence for seeking help for depression and suicidality has highlighted a range of important issues. These include low literacy [30], social stigma and self-stigma [3], and fear of being seen as weak for having a mental illness, a perceived deficit amplified by some men's inability to self-manage and/or conceal their ailment amid giving in to "needing" as well as "taking" professional help [31•]. Men's resistance to help-seeking has most often been explained by their alignments to masculine norms (e.g., strength, stoicism, and self-reliance) [31•]. Seidler and colleagues' [32••] review of 37 men's depression help-seeking studies acknowledged the potential for some masculine ideals to affirm and norm men's mental health help-seeking. This review suggested that strength- and courage-based masculine norms could be used to promote men's depression help-seeking [32••]. This position was supported in a recent Australian randomized controlled trial reporting that a male-focused documentary on men's mental health had the capacity to shift adherence to maladaptive masculine norms and improve men's help-seeking intentions [33]. The influence of these de-stigmatizing efforts has likely added positively to the recent increase in men's help-seeking for mental health concerns [34].

In addition to these broader society-wide efforts, related literature has investigated a range of individual factors potentially influencing men's help-seeking intentions. Call and Shafer [35] found that male depression symptoms alone (i.e., aggression, substance misuse) did not increase the odds of men seeking help for depression. Rice et al. [16] reported that men with unremitting prototypic depression symptoms over 15 weeks experienced greater help-seeking barriers than those with resolved symptoms or no symptoms. Adding to this, Ogrodniczuk et al. [36] highlighted the juxtaposition embedded in Canadian men's acknowledgement that depression was a serious health concern amid self-reporting that they were poorly informed, and without the tools necessary to access help themselves. Collectively, these findings regarding men's help-seeking intentions confirmed significant knowledge deficits and barriers related to treatment for depression and suicidality among men, pointing to the potential benefits of tailored public health campaigns and targeted information (e.g., [33]). While men's reticence for depression and suicidality help-seeking may be reduced by strength-based masculinities, public awareness raising and de-stigmatizing efforts [31•], the focus on men's engagement with professional mental health also bares many complexities and challenges for men who do access services.

Driven by consistent findings that up to 60% of men who suicide have accessed professional health care services in the year leading up to their death [29], research investigating men's engagement with professional mental health care has grown in recent times. The need for, as well as the intricacies of this work was highlighted in a study by Wide et al. [37•], wherein four of the 97 male respondents indicated current suicidal thoughts (via a confidential demographic questionnaire) in the clinic waiting room ahead of seeing their family physician. However, in the post-consult check of the four men's medical notes, there was no suggestion that the men had disclosed suicidal thoughts to their physician. That four respondents were potentially at risk for suicide amid engaging professional help [37•] underscored the need to better understand the interplay between men's help-seeking and professional health services [38]. Some work has investigated men's perspectives about, and preferences for professional care. Whittle et al.'s [39] review of 17 studies investigating men's accounts of depression and suicidality indicated penchants for practical solutions and problem solving. Berger et al. [40] reported that having a genuine connection and mutual understanding with clinicians was critical to men's willingness to talk openly about their depression. Among men who had received psychotherapy for depressive symptoms, the benefits

of active strength-based approaches to empower and bridge men toward effective self-management of depressive symptoms were highlighted [41]. Based on findings from Seidler et al. [41], exploration of men's depression treatment experiences, three recommendations were offered to improve men's engagement with professional mental health care: (1) orient to system, (2) establish trust and share control, and (3) action emphasis toward empowerment.

Building on the literature describing men's experiences of professional mental health care services has been an effort to develop guidelines for working with boys and men. Seidler et al.'s [42•] scoping review of 46 articles reporting recommendations for treating men underscored the need for clinician's to reflect on the influence of their own, as well as the client's gender socialization, the importance of providing clearly structured, transparent and goal-oriented interventions, and the incorporation of strength-based approaches to build rapport and therapeutic alliances. Seidler et al.'s [42•] review argued for, and mapped gender-sensitized clinical services as the means to more fully engaging men in psychological treatments, with practitioners and researchers in the field echoing these calls, most recently in a Delphi expert consensus study [43]. Moreover, Grace et al.'s [44] study of service providers' perspectives reported that creating safety, trust, rapport, and meaningful relationships was the gateway to sustained connection with professional services. The recently released American Psychological Association guidelines for psychological practice lobbied psychologists with 10 gender-based "strategies" for working with boys and men [45] and have drawn diverse ontological, epistemological, and political debates [46]. This has been somewhat divisive with oppositional sides viewing the guidelines as positioning men and masculinity as the problem versus a lack of system reform for the services offered to men [47]. A further issue for the field is that marginalized subgroups of men, including gay and Indigenous men, might have their experiences and needs subsumed or assumed to fit within an overarching, all-encompassing masculinity framework (wherein gender vis-à-vis masculinity is de-linked from other social determinants of health) [48, 49].

In summary, it is important to recognize that some men's reticence for seeking help prevails. Therefore, reformulating restrictive masculine norms by affirming men's mental health challenges and uptake of professional care is critical. Likewise, literature addressing men's engagement with professional mental health care has shed important light on strategies intended to optimize male care for depression and suicidality.

Conclusion

By recognizing male depression symptoms—both prototypic and externalizing—and being cued to the barriers and the nuances of men's help-seeking for depression and suicidality, clinical services can be adjusted to afford important benefits to men. These adjustments are, however, reliant on translating long-standing depression and suicide sex differences work, as well as emergent gender-sensitized guidelines to tailor clinical services. To clarify, the findings from, and discussion of this recent literature are not solely a call to action for practitioners; rather, a need for reciprocity is acknowledged wherein clinical services also shape research and policy to advance men's mental health. Related to this point, "help" for men's depression and suicidality has increasingly diversified to peer- and community-based approaches as well as interventions offered through social media and e-health platforms [50, 51]. Much of this promising work can augment—and shape and be shaped by—clinical services, in collectively better understanding and addressing the discordant relationship between men's low rates of formally diagnosed depression and high suicide rates [5•].

Though much of the work in men's depression and suicidality originates from sex differences research, the potential benefits of tailored men's mental health services are increasingly evident and critically important. In sum, advances in screening, diagnosing, and effectively treating male depression and suicidality have essential benefits for all—women, children, other men, and those who identify on the continuums between male and female binaries. The multiple "causes" driving men's depression and suicide work are therefore worthy of continued investment from a social justice viewpoint, and the capacity for diminishing the emotional and economic burden and suffering that accompany male depression and suicide.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

Human and Animal Rights All reported studies with human subjects performed by the authors have been previously published and complied with all applicable ethical standards (including the Helsinki Declaration and its amendments, institutional/national research committee standards, and international/national/institutional guidelines).

References

Papers of particular interest, published recently, have been highlighted as:
• Of importance
•• Of major importance

1. World Health Organization. Suicide Data. 2019. https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/. Accessed 27 May 2019.

2. Branney P, White A. Big boys don't cry: depression and men. Adv Psychiatr Treat. 2008;14(4):256–62. https://doi.org/10.1192/apt.bp.106.003467.
3. Oliffe JL, Ogrodniczuk JS, Gordon SJ, Creighton G, Kelly MT, Black N, et al. Stigma in male depression and suicide: a Canadian sex comparison study. Community Ment Health J. 2016;52(3):302–10. https://doi.org/10.1007/s10597-015-9986-x.
4. Lee C, Oliffe JL, Kelly MT, Ferlatte O. Depression and suicidality in gay men: implications for health care providers. Am J Mens Health. 2017;11(4):910–9. https://doi.org/10.1177/1557988316685492.
5.• Oliffe JL, Phillips MJ. Men, depression and masculinities: a review and recommendations. J Mens Health. 2008;5:3. https://doi.org/10.1016/j.jomh.2008.03.016. **This review article was among the first to map connections between masculinity and men's depression and suicide.**
6. World Health Organization. Depression and other common mental disorders: global health estimates. 2017. 4–14.
7. Rutz W, Wålinder J, Von Knorring L, Rihmer Z, Pihlgren H. Prevention of depression and suicide by education and medication: impact on male suicidality. An update from the Gotland study. Int J Psychiatry Clin Pract. 1997;1(1):39–46. https://doi.org/10.3109/13651509709069204.
8. Genuchi M. Anger and hostility as primary externalizing features of depression in college men. Int J Mens Health. 2015;14(2):113–28.
9.•• Martin LA, Neighbors HW, Griffith DM. The Experience of symptoms of depression in men vs women analysis of the National Comorbidity Survey Replication. JAMA Psychitr. 2013;70(10):1100–6. **This study found that when traditional and male-type symptoms of depression are combined, the sex disparities in the prevalence of depression are eliminated.**
10. Rutz W, Von Knorring L, Pihlgren H, Rihmer Z, Walinder J. Prevention of male suicides: lessons from Gotland study. Lancet. 1995;345:524.
11. Athanasiadis C, Gough B, Robertson S. What do counsellors need to know about male depression? Br J Guid Couns. 2018;46(5):596–604. https://doi.org/10.1080/03069885.2017.1346232.
12. Rice SM, Fallon B, Aucote H, Möller-Leimkühler A. Development and preliminary validation of the Male Depression Risk Scale: furthering the assessment of depression in men. J Affect Disord. 2013;151:950–8. https://doi.org/10.1016/j.jad.2013.08.013.
13. Zierau F, Bille A, Rutz W, Bech P. The Gotland Male Depression Scale: a validity study in patients with alcohol use disorder. Nord J Psychiatry. 2002;56:265–71. https://doi.org/10.1080/08039480260242750.
14.• Cavanagh A, Wilson CJ, Kavanagh DJ, Caputi P. Differences in the expression of symptoms in men versus women with depression: a systematic review and meta-analysis. Harv Rev Psychiatry. 2017;1:29–38. https://doi.org/10.1097/HRP.0000000000000128. **This article is a comprehensive review of the sex differences literature related to expression of depressive symptoms.**
15. Rice SM, Kealy D, Oliffe JL, Ogrodniczuk JS. Male-type depression symptoms linked to broader psychopathology. J Affect Disord. 2018;235:523–4. https://doi.org/10.1016/j.jad.2018.04.062.
16. Rice SM, Aucote HM, Möller-Leimkühler AM, Amminger GP. Confirmatory factor analysis of the Gotland Male Depression Scale in an Australian community sample. Eur J Psychol Assess. 2017;33:190–5. https://doi.org/10.1027/1015-5759/a000287.
17. Magovcevic M, Addis ME. The Masculine Depression Scale: development and psychometric evaluation. Psychol Men Masculinity. 2008;9(3):117–32. https://doi.org/10.1037/1524-9220.9.3.117.
18. Kroenke K, Spitzer RL. The PHQ-9: a new depression diagnostic and severity measure. Psychiatr Ann. 2002;32(9):509–15. https://doi.org/10.3928/0048-5713-20020901-06.
19.• Rice SM, Fallon BJ, Aucote HM, Möller-Leimkühler A, Treeby MS, Amminger GP. Longitudinal sex differences of externalising and internalising depression symptom trajectories: implications for assessment of depression in men from an online study. Int J Soc Psychiatry. 2015;61(3):236–40. https://doi.org/10.1177/0020764014540149. **This study contributed to the validity of the Men's Depression Risk Scale (MDRS) suggesting that externalizing symptoms may be a feature of depression in men.**
20.• Rice SM, Ogrodniczuk JS, Kealy D, Seidler ZE, Dhillon HM, Oliffe JL. Validity of the Male Depression Risk Scale in a representative Canadian sample: sensitivity and specificity in identifying men with recent suicide attempt. J Ment Health. 2019;2:132–40. https://doi.org/10.1080/09638237.2017.1417565. **In this study, the MDRS psychometric values were found to be comparable with the PHQ-9 with validation of the MDRS extended to cross-nation samples.**
21. Rice SM, Oliffe JL, Kealy D, Ogrodniczuk JS. Male depression subtypes and suicidality: latent profile analysis of internalizing and externalizing symptoms in a representative Canadian sample. J Nerv Ment Dis. 2018;206(3):169–72. https://doi.org/10.1097/NMD.0000000000000739.
22. Kilmartin C. Depression in men: communication, diagnosis and therapy. J Mens Health Gender. 2005;2(1):95–9. https://doi.org/10.1016/j.jmhg.2004.10.010.
23. Genuchi MC, Mitsunaga LK. Sex differences in masculine depression: externalizing symptoms as a primary feature of depression in men. J Mens Stud. 2015;23(3):243–51. https://doi.org/10.1177/1060826514561986.
24. Genuchi MC, Valdez JN. The role of anger as a component of a masculine variation of depression. Psychol Men Masculinity. 2015;16(2):149–59. https://doi.org/10.1037/a0036155.
25. Oliffe JL, Galdas PM, Han CSE, Kelly M. Faux masculinities among college men who experience depression. Health. 2012;17(1):75–92. https://doi.org/10.1177/1363459312447256.
26. Oliffe JL, Creighton G, Robertson S, Broom A, Jenkins EK, Ogrodniczuk JS, et al. Injury, interiority and isolation in men's suicidality. Am J Mens Health. 2017;11(4):888–99. https://doi.org/10.1177/1557988316679576.
27. Cleary A. Help-seeking patterns and attitudes to treatment amongst men who attempted suicide. J Ment Health. 2017;26(3):220–4. https://doi.org/10.3109/09638237.2016.1149800.
28. Harris MG, Diminic S, Reavley N, Baxter A, Pirkis J, Whiteford HA. Males' mental health disadvantage: an estimation of gender-specific changes in service utilisation for mental and substance use disorders in Australia. Aust N Z J Psychiatry. 2015;49(9):821–32. https://doi.org/10.1177/0004867415577434.
29. Schaffer A, Sinyour M, Kurdyak P, Vigod S, Sareen J, Reis C, et al. Population-based analysis of health care contacts among suicide decedents: identifying opportunities for more targeted suicide prevention strategies. World Psychiatry. 2016;15(2):135–45. https://doi.org/10.1002/wps.20321.
30. Oliffe JL, Hannan-Leith MN, Ogrodniczuk JS, Black N, Mackenzie CS, Lohan M, et al. Men's depression and suicide literacy: a nationally representative Canadian survey. J Ment Health. 2016;25(6):520–6. https://doi.org/10.1080/09638237.2016.1177770.
31.• Struszczyk S, Galdas PM, Tiffin PA. Men and suicide prevention: a scoping review. J Ment Health. 2019;1:80–8. https://doi.org/10.1080/09638237.2017.1370638. **This review chronicled male suicide prevention interventions and their perspectives on professional services offering key insights to men's mental health help-seeking.**
32.•• Seidler ZE, Dawes AJ, Rice SM, Oliffe JL, Dhillon HM. The role of masculinity in men's help-seeking for depression: a systematic review. Clin Psychol Rev. 2016;49:106–18. https://doi.org/10.1016/j.cpr.2016.09.002. **This highly cited review synthesizes the literature addressing masculinity and depression help-seeking to offer masculine norms as potential risk or benefit.**

33. King KE, Schlichthorst M, Spittal MJ, Phelps A, Pirkis J. Can a documentary increase help-seeking intentions in men? A randomised controlled trial. J Epidemiol Community Health. 2018;72(1):92–8. https://doi.org/10.1136/jech-2017-209502.
34. Schlichthorst A, King K, Turnure J, Phelps A, Pirkis J. Engaging Australian men in masculinity and suicide – a concept test of social media materials and a website. Health Promot J Austr. 2019;2019: 1–12. https://doi.org/10.1002/hpja.246.
35. Call JB, Shafer K. Gendered manifestations of depression and help seeking among men. Am J Mens Health. 2018;12:41–51. https://doi.org/10.1177/1557988315623993.
36. Ogrodniczuk JS, Oliffe JL, Black N. Canadian men's perspectives of depression: awareness and intention to seek help. Am J Mens Health. 2017;11(4):877–9. https://doi.org/10.1177/1557988316669617.
37.• Wide J, Mok H, Mc Kenna M, Ogrodniczuk JS. Effect of gender socialization on the presentation of depression among men: a pilot study. Can Fam Physician. 2011;57(2):e74–8. **A novel study that points to the complexities of men who access professional care but do not disclose suicidal thoughts to the treating physician.**
38. River J. Diverse and dynamic interactions: a model of suicidal men's help seeking as it relates to health services. Am J Mens Health. 2018;12:150–9. https://doi.org/10.1177/1557988316661486.
39. Whittle EL, Fogarty AS, Tugendrajch S, Player MJ, Christensen H, Wilhelm K, et al. Men, depression, and coping: are we on the right path? Psychol Men Masculinity. 2015;16(4):426–38. https://doi.org/10.1037/a0039024.
40. Berger JL, Addis ME, Green JD, Mackowiak C, Goldberg V. Men's reactions to mental health labels, forms of help-seeking, and sources of help-seeking advice. Psychol Men Masculinity. 2013;14(4):433–43. https://doi.org/10.1037/a0030175.
41. Seidler ZE, Rice SM, Oliffe JL, Fogarty AS, Dhillon HM. Men in and out of treatment for depression: strategies for improved engagement. Aust Psychol. 2018;53(5):405–15. https://doi.org/10.1111/ap.12331.
42.• Seidler ZE, Rice SM, Ogrodniczuk JS, Oliffe JL, Dhillon HM. Engaging men in psychological treatment: a scoping review. Am J Mens Health 2018:1882–1900. https://doi.org/10.1177/1557988318792157. **Innovative review synthesizing what engages men with mental health care in making recommendations for future practice and research.**
43. Seidler ZE, Rice SM, Ogrodniczuk JS, Oliffe JL, Shaw JM, Dhillon HM. Men, masculinities, depression: implications for mental health services from a Delphi expert consensus study. Prof Psychol Res Pract. 2019;50(1):51–61. https://doi.org/10.1037/pro0000220.
44. Grace B, Richardson N, Carroll P. ". . . If You're not part of the institution you fall by the wayside": service providers' perspectives on moving young men from disconnection and isolation to connection and belonging. Am J Mens Health. 2018;12(2):252–64. https://doi.org/10.1177/1557988316634088.
45. American Psychological Association. Boys and men guidelines group: APA guidelines for psychological practice with boys and men. 2018. http://www.apa.org/about/policy/psychological-practice-boys-men-guidelines.pdf. Accessed 20 May 2019.
46. Quillette Magazine. Twelve scholars respond to the APA's guidance for treating men and boys. 2019. https://quillette.com/2019/02/04/psychologists-respond-to-the-apas-guidance-for-treating-men-and-boys/. Accessed 26 May 2019.
47. Chen A. New therapist guidelines receive criticism for claim that traditional masculinity harms men. The Verge. 2019. https://www.theverge.com/2019/1/11/18178346/masculinity-therapist-guidelines-american-psychological-association-apa-mental-health. Accessed 25 May 2019.
48. Centre for Suicide Prevention. Indigenous Suicide Prevention. 2013. https://www.suicideinfo.ca/resource/indigenous-suicide-prevention/. Accessed 27 May 2019.
49. Ferlatte O, Salway T, Hankivsky O, Trussler T, Oliffe JL, Marchand R. Recent suicide attempts across multiple social identities among gay and bisexual men: an intersectionality analysis. J Homosex. 2018;65(11):1507–26. https://doi.org/10.1080/00918369.2017.1377489.
50. Fogarty AS, Proudfoot J, Whittle EL, Clarke J, Player MJ, Christensen H, et al. Preliminary evaluation of a brief web and mobile phone intervention for men with depression: men's positive coping strategies and associated depression, resilience, and work and social functioning. JMIR Ment Health. 2017;4(3):e33. https://doi.org/10.2196/mental.7769.
51. Ogrodniczuk JS, Oliffe JL, Beharry J. HeadsUpGuys: a Canadian online resource for men with depression. Can Fam Physician. 2018;64(2):93–4.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.