Article

Beyond Workers' Compensation: Men's Mental Health In and Out of Work

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Abstract

The mental health of men is an important issue with significant direct and indirect costs emerging from work-related depression and suicide. Although the merits of men's community-based and workplace mental health promotion initiatives have been endorsed, few programs are mandated or formally evaluated and reported on. Conspicuously absent also are gender analyses detailing connections between masculinities and men's work-related depression and suicide on which to build men-centered mental health promotion programs. This article provides an overview of four interconnected issues, (a) masculinities and men's health, (b) men and work, (c) men's work-related depression and suicide, and (d) men's mental health promotion, in the context of men's diverse relationships to work (including job insecurity and unemployment). Based on the review, recommendations are made for advancing the well-being of men who are in as well as of those out of work.

Keywords

work-related health, depression, suicide, hegemonic masculinity, gender socialization

Introduction

The most prominent male workplace health statistics are injury rates and the associated economic costs. In Canada, in 2008, one out of every 46 workers had a compensated time-loss injury for which the Workers' Compensation Board paid a total of CA$7.67 billion in benefit payments, along with CA$2.03 billion for health care and vocational rehabilitation costs (Gilks & Logan, 2010). Responding to these trends, an array of occupational health and safety guidelines and programs have been legislated and implemented, with formal report lines to monitor those efforts. In addition to physical injuries, workplace mental health issues have emerged as a key concern. In 2009-2010, 78% of the short-term and 67% of long-term disability claims in North America were related to mental health issues (Towers Watson, 2009). Researchers suggest that these figures are likely higher because many male workers are reticent to seek professional help and/or fearful of disclosing their mental illness issues to employers (Thorpe & Chenier, 2011; Winkler, Pjrek, & Kasper, 2006).

In addition to workplace-specific issues, ongoing economic instability has increased mental health vulnerabilities among men who are challenged to comfortably retire, or find and sustain paid work. In this regard, mental illnesses have increased over the last decade for men who are in as well as out of work. Particularly prominent are men's depression and suicide, and their significant disease burden, for which targeted mental health promotion strategies are required (Andrade et al., 2003; Government of Canada, 2006; Mathers et al., 2003; Public Health Agency of Canada, 2002). That said, conspicuously absent are gender analyses connecting masculinities and men's work-related depression and suicide, and how best to address these issues.

This article provides an overview of four distinct yet interconnected areas, (a) masculinities and men's health, (b) men and work, (c) men's work-related depression and suicide, and (d) men's mental health promotion. Recommendations are made for how efficient avenues for advancing men's work-related mental health might be garnered.

Masculinities and Men's Health

Over the past 20 years, Connell's (1995) work in masculinities has been adapted to address an array of men's

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health and illness issues. Central to this social constructionist gender framework are two principles: (a) patriarchal power and characteristics, including self-reliance and competitiveness, are understood as hegemonic masculine ideals that influence men's gendered practices and performances and (b) a plurality of context-dependent masculinities shape and are shaped by dominant ideals of hegemonic masculinity. Connell's (1995) framework has proved remarkably robust for investigating diverse men's health issues; however, three substantial challenges prevail.

First, although Connell (1995) detailed masculinities as relational, much of the men's health research has focused on men's self-reports of *their* health practices and illness experiences. A limitation of this approach is that masculinity can be portrayed as operating independently and/or entirely in response to hegemonic masculine ideals, even though these ideals and gender performances are context-dependent, relational, and co-constructed (Connell & Messerschmidt, 2005). For example, while a man might rely on his spouse for health advice, he might simultaneously avoid disclosing any health concerns to his work colleagues or supervisor. Evident in this example is how specific gender relations can lead men to seek counsel (and perhaps permission to see a doctor) from a partner but conceal health concerns from their employer to protect their job.

Second, some men's health research has portrayed masculinity as monolithic, whereby related social determinants of health (e.g., socioeconomic status, social class, and culture, etc.) are implicit or absent from these "gender" analyses. In response, Lohan (2007) argued for life-course approaches, and Creighton and Oliffe (2010) recommended a community of practice framework, whereas Griffith (2012) advocated for intersectionality as the remedy to stem the compartmentalizing and essentializing of masculinity in men's health research. Common to each of these recommendations were assertions that masculinities be operationalized as intersecting with an array of social contexts to develop nuanced accounts about men's health practices and outcomes (Evans, Frank, Oliffe, & Gregory, 2011). In the specific example of work-related depression and suicide, analyzing masculinities as they intersect with socioeconomic status, social class, and culture to explore micro-level conditions (such as work pace and stress) and macro-level issues of unemployment and job insecurity can provide important insights to vulnerable subgroups of men, as well as guide targeted upstream prevention efforts (Mikkonen & Raphael, 2010).

Third, although the masculinities and men's health literature has described an assortment of important issues, few have transitioned to interventions. Many factors have stalled or disconnected descriptive research findings from informing potential men's mental health remedies. Foremost, the sociological origins of the masculinities framework have led some researchers to focus on theory development and debates (Coles, 2009; Flood, 2011; Pease, 2009). Furthermore, it takes time to build research program capacity to design, deliver and formally evaluate interventions, and the masculinities and men's mental health research is a relatively new, emergent area. Related to this, it can also be challenging to lobby for, and/or sustain the delivery of men-centered clinical services, especially given the widespread budget constraints and increasing demand for finite basic health services. Overall, the application of masculinities and men's health research can be advanced by focusing on subgroups (e.g., men in specific occupations and work hierarchies, unemployed, retired) and mental health issues (i.e., depression and suicide) with an explicit goal of rapidly translating the findings toward targeted mental health promotion programs.

In sum, by attending to the relational nature of gender and the intersections with 'other' social determinants of health, masculinities and men's health research can efficiently guide what, where, to whom and how empirical knowledge is applied to garner men-centered mental health remedies.

Men and Work

Masculinities research has eloquently detailed the centrality of work and/or career to men's lives. Collinson and Hearn (1996), for example, reported five masculinity tropes that men enact at work, of which the most common was the "macho" management style "emphasizing qualities of struggle and battle, a willingness to be ruthless and brutal, a rebellious nature and an aggressive, rugged individualism" (p. 3). Extending on this finding, "man"-agement came to be defined in terms of the ability to control people, events, companies, environments, trade unions and new technology" (Collinson & Hearn, 1996, p. 3). Collinson and Hearn (2005) also described organizations as sites for the reproduction of men's power whereby performativity around structure, control, decision making, and remuneration reflected, as well as reinforced, hegemonic masculine ideals.

Many men in Western countries buy into these masculine workplace norms by defining themselves according to their jobs and evaluating their worth across the boundaries of public and private, paid and unpaid work (Kilmartin, 2007). Decision-making and strategic planning, activities that define idealized masculinity, afford managerial control and power that routinely excludes and subordinates less-powerful workers. Hegemonic marketplace masculinities, Kimmel (1994) asserted—typified by aggression, competition, and anxiety among men who

focus on outperforming one another at work—can also coexist alongside men who resist such masculine ideals. For example, as men grow older, they are often less able to compete effectively with younger, "hungrier" and more aggressive male colleagues (Collinson & Hearn, 2005). Such circumstances can precede older men's estrangement from the masculine man-as-breadwinner associations with work and money (Buchbinder, 2002), and, similarly, men facing retirement can experience that impending change as a significant threat to their masculinity (Calasanti & King, 2005).

Although the masculinities and work literature has skillfully applied, and in some cases extended on Connell's (1995) framework to critically evaluate men's management styles and power relations in the workplace, few direct linkages have been made to men's health. Among the exceptions, Dolan (2007, 2011) conducted a study to investigate linkages between working-class masculinities and men's health care practices. Included were comparative analyses of affluent and relatively nonaffluent U.K.-based participants (11 participants from each "ward" or suburb). The findings revealed paid employment as the conduit for fulfilling provider roles, and negative health behaviors (e.g., smoking, drinking, risk-taking behaviors) were used to win respect among colleagues amid normalizing exposure to dangerous manual and heavy labor industries (Dolan, 2007, 2011). In concluding, Dolan (2007, 2011) argued that certain risky practices were firmly rooted in the material reality of men's lives, which in turn could account for why certain negative health practices persist among economically disadvantaged groups of men. Another U.K.-based gender comparison study addressing work–life balance that included 11 men in their 50s found that participants who "worked to live" ran counter to hegemonic masculinity, ascribing that real men "live to work" (Emslie & Hunt, 2009). Although these studies linked masculinities, work, and men's health, little was offered for how the findings might be used to advance the health of specific subgroups of male workers.

In contrast to sociological commentaries and studies theorizing men's gendered connections to work, remedying problems is key to lobbying health research funders to invest in masculinities and men's health studies. Divergent sociological and health research goals have also fuelled debate about how masculinity frameworks are and should be operationalized. As recently pointed out, some masculinities and men's health research, while claiming social constructionist gender frameworks, essentially offer trait-based explanations to distil men's health behaviors and illness experiences (Messerschmidt, 2012). Connecting the masculinities and work, and masculinities and health silos through cross-disciplinary collaborations, while challenging, might equally advance theory and empirical understandings about how best to promote men's work-related mental health.

Men's Work-Related Depression and Suicide

Comparatively, in Western countries, men are formally diagnosed with depression at approximately half the rate of women (Kessler et al., 2005; Wilhelm, Parker, Geerligs, & Wedgwood, 2008). Commentaries about men's depression, however, suggest that the lower reported rates might be due to the widespread use of generic diagnostic criteria that are not sensitive to depression in men (Blair-West & Mellsop, 2001; Brownhill, Wilhelm, Barclay, & Schmied, 2005; Cochran & Rabinowitz, 2003; Courtenay, 1998; Kilmartin, 2005; Winkler et al., 2006; Winkler, Pjrek, & Heiden, 2004), as well as men's reluctance to express concerns about their mental health and reticence to seek professional health care (Emslie, Ridge, Ziebland, & Hunt, 2006; Sharpe & Heppner, 1991; Winkler et al., 2006). Severe depression can also significantly increase the risk for suicide; yet despite low reported rates of male depression (Emslie et al., 2006; Kessler et al., 2005; Wilhelm et al., 2008; World Health Organization, n.d.), suicide rates are approximately four times higher in Western men than in women (Centers for Disease Control and Prevention, 2012; Hawton & van Heeringen, 2009; Levi et al., 2003; Moller-Leimkuhler, 2003; Rihmer, Belso, & Kiss, 2002; Statistics Canada, 2012a, 2012b; Wasserman, 2000; Wolfgang & Zoltan, 2007). The discordant relationship between men's depression and suicide has led researchers to describe some contributing and confounding work-related factors.

Depressed workers are more likely to retire than non-depressed workers (Doshi, Cen, & Polsky, 2008) and men of lower socioeconomic status are at greater risk for hopelessness and depression (Soares, Macassa, Grossi, & Viitasara, 2008). Mutran, Reitzes, and Fernandez (1997) predicted that the greater the intrinsic value of men's work, the lesser the retirement satisfaction; whereas Butterworth et al. (2006) claimed that an older retirement age (65-74 years) results in a lower prevalence of mental illness among men. Furthermore, complex recursive relationships between masculinities and men's work and depression have been highlighted in qualitative studies. Bennett (2007) reported how older widowers immersed themselves in work to distance themselves from the grief and depression associated with losing a partner, while Oliffe et al. (in press) described how depression could be waylaid by, as well as emerge from, older men's paid work. Other studies have detailed how academic underperformance and falling short of career goals rendered college men more susceptible to depression (Oliffe et al., 2010), whereas a study of middle-aged men highlighted

how depressed men can be forced to relinquish their workman and primary breadwinner roles (Oliffe, Kelly, Bottorff, Johnson, & Wong, 2011).

In terms of men's work-related suicide, high suicide rates prevail in male-dominated workgroups, including manual workers (Roberts, Jaremin, & Lloyd, 2012) and within occupations of farming (Hempstead, Nguyen, David-Rus, & Jacquemin, 2012; Roy, Tremblay, Oliffe, Jbilou, & Robertson, 2013) and the military (Trofimovich, Reger, Luxton, & Oetjen-Gerdes, 2013). That said, suicide mortality by occupation can vary significantly by locale. A Canadian study revealed elevated risk of suicide among men in nursing, whereas a protective effect was afforded to men in management occupations (Mustard et al., 2010). Typically hypothesized as causative for men's occupation-specific suicide are high pressure workplaces and burnout (Meltzer, Griffiths, Brock, Rooney, & Jenkins, 2008) and/or greater access to means by which to suicide (Miller & Hemenway, 2008). Conspicuously absent from articles that demarcate occupation-specific male suicide patterns are gender analyses—more specifically, few inferences are made about how masculinities might inform and influence these trends.

Linkages between men's work, depression, and suicide have also been described. Self-perceptions of being a "failed breadwinner" led older men with a history of depression to think about suicide (Oliffe, Han, Ogrodniczuk, Phillips, & Roy, 2011), whereas some middle-aged men countered suicidal ideations by focusing on work as a means of providing for their family (Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012). Though extreme, also particularly worrisome are work- and school-based homicide-suicides, which most often feature male perpetrators (Kalish & Kimmel, 2010). A review by Roma et al. (2012) confirmed depression as the primary preexisting mental illness among men who murder–suicide, and workplace grievances and conflict have underpinned some of these tragic events.

Given the ongoing challenges associated with what has been labeled the *great recession*, mental illness among men who are challenged to retire comfortably or find and sustain paid work has drawn research and media attention. Indeed, unemployment, job insecurity, and forced "early" retirement have ruptured many men's work (de Guerre & Galea-Davis, 2011) and "salary man" identities (Iida & Morris, 2008), leading some men toward depression and/or suicide (Brand, Levy, & Gallo, 2008; Chan, Yip, Wong, & Chen, 2007). Globally, the extent and specificities of these work-related vulnerabilities continue to surface. For example, the 2008 stock market crash shed 5.5 million jobs in the United States, 80% of which were lost by men; and by 2010, only 39% of older workers aged 55 to 64 years, and 23% of workers older than 65 years were reemployed (U.S. Bureau of Labor Statistics, 2011). Similarly, in Canada (Uppal, 2010) and the United Kingdom, (Dini, 2009; Macnicol, 2008), the recession has seen the majority of job losses in the manufacturing, construction, natural resources, and transportation industries—sectors traditionally dominated by men. Significant are predictions that 96% of employment growth in the United States is expected to occur in service-provision sectors (e.g., health care and social assistance), occupations traditionally dominated by women (U.S. Bureau of Labor Statistics, 2012). These statistics reflect system-related workforce changes whereby men's increasing unemployment rates can lead to poverty and distress, which in turn increases men's depression and suicide rates (Cooper, 2011; Mattingly, Smith, & Bean, 2011; Milner, Page, & LaMontagne, 2012, 2013). The Irish Institute of Public Health report, *Facing the Challenge: The Impact of Recession and Unemployment on Men's Health in Ireland*, similarly chronicled the need to strategically intervene in recommending that depression and suicide prevention programs be targeted at unemployed men (Dillon & Butler, 2011).

Clearly, work is central to men's masculine identities, roles and relations, and many work-related factors including stress, unemployment, and job insecurity are intricately connected to men's depression and suicide (Mäki & Martikainen, 2012). As such, deciphering work-related depression and suicide risk factors is key to devising protections and promoting the mental health of men who are in as well as out of work.

Men's Mental Health Promotion

Much of the early men's health promotion literature focused on men's estrangement from their health. Courtenay (2000), Kimmel (2008) and Sabo (2005), for example, explained that men's resistance to promoting their health and reticence to seek professional services reflected the constrained choices that flowed from aligning to masculine ideals of self-reliance, competitiveness, and aggression. More recently, men's health promotion research has highlighted how strength-based approaches trading on masculine ideals of problem-solving and provider and protector roles can engage men with *their* health on *their* own terms. Recognized were the existence of diverse motivations and self-health practices and the need to attend to the heterogeneous nature of subgroups of men (Oliffe, Bottorf, et al., 2011; Robertson & Williamson, 2005; Smith & Robertson, 2008; Whitley, Jarrett, Young, Adeyemi, & Perez, 2007).

Program principles, including (a) the use of positive messaging to promote change without amplifying stigma, guilt, shame, and blame; (b) fostering connections between masculine ideals (e.g., strength, decisiveness,

resilience, autonomy, rationality) and health; and (c) privileging the testimonials of potential end-users to ensure authenticity, have resonated as essential to effective men-centered health promotion (Oliffe, Bottorff, & Sarbit, 2012). Specific program implementation strategies have also been detailed. In response to concerns that some men are interested in discussing their health but do not for fear of ridicule and stigma (Dolan, Staples, Summer, & Hundt, 2005; Whitley et al., 2007), Gibson and Denner (2000) suggested that the permission of other men was the elixir for promoting men's talk about health concerns. A similar viewpoint was shared in empirical research detailing key ingredients central to the effectiveness of North American–based prostate cancer support groups (Arrington, Grant, & Vanderford, 2005; Oliffe, Bottorf, et al., 2011). The aforementioned program principles and strategies have been mobilized in community-based and virtual environments, a trend influenced by social marketing theory, which argues that men are best engaged with their health by messaging them in the places where they ordinarily gather (e.g., pubs, sporting venues, online; Courtenay, 2003). In line with social marketing, the workplace is recognized as an ideal insertion point for men's health promotion programs. Indeed, the *2008-2013 Ireland's Men's Health Report* (Richardson & Carroll, 2008) suggested that the cohesive involvement of employers and unions was pivotal to tapping the full potential of men's workplace health initiatives. A few workplace programs, including the U.K.-based men's health intervention, focused on weight management have been chronicled (White, Conrad, & Branney, 2008), while e-health promotion has been touted as especially appealing to young men who want to be anonymous in their self-health efforts (Robinson & Robertson, 2010).

In the specific context of workplace mental health programs, participatory approaches and designated frontline business champions can foster work cultures that actively promote workers' mental health (Robinson, Tilford, Branney, & Kinsella, 2013). Specific strategies such as workplace lunchtime talks about stress and anger management, depression, relationship skills, conflict resolution and healthy lifestyles have been listed as effective means for building men's resilience and increasing the likelihood of help seeking in a crisis (Beaton & Forster, 2012). Treatment services specializing in men's work-related mental health issues can also quell occupational stress and burnout (Lander & Nahon, 2008). Examples of successful workplace suicide prevention programs include mates in construction (http://www.matesinconstruction.com.au/; Gullestrup, Lequertier, & Martin, 2011) and working minds (http://softenthefckup.com.au/betterifyourearound/; Beaton & Forster, 2012). Evident within emergent face-to-face and virtual work-related men's mental health programs is the strong potential to message men directly at work and/or to engage them virtually as a member of a specific workgroup.

The mental health benefits for unemployed men connecting with empathetic services and other men in similar circumstances has been emphasized (Dillon & Butler, 2011), and a few community-based men's mental health promotion programs have been designed to target this "high-risk" subgroup. Featured most prominently is the Australian Men's Sheds program, a federally funded initiative providing workshop-type spaces in community settings for regular hands-on activity that has engaged many men facing significant life changes including aging, retirement, unemployment, disability, and separation (Ballinger, Talbot, & Verrinder, 2009; Golding, Brown, Foley, Harvey, & Gleeson, 2007). Men's Sheds have also been successfully adapted in New Zealand (Australian Men's Shed Association; http://www.mensshed.org/home/.aspx), Ireland (Irish Men's Shed Association, 2012; http://www.menssheds.ie/) and the United Kingdom (United Kingdom Men's Shed Association, 2012; http://www.menssheds.org.uk/; Williamson, 2010).

In summary, consensus prevails that strength-based approaches are the contemporary cornerstone of effective programs advancing men's work-related mental health. For men in work, workplace-based interventions are especially promising, while community-based and programs delivered virtually can also reach and support men who are unemployed or retired. Although there are many potential benefits, the ever-increasing burden of proof demands that men's mental health promotion programs report formal objective evaluations to demonstrate the cost–benefits of such interventions (as distinct from parochial assurances that particular programs are well received and making a difference to men's lives; Wilson & Cordier, 2013). To this end, longitudinal studies strategically collecting a range of data including workplace absenteeism and men's self-reported mental health, depression, and suicidal ideation scores will be needed to build the empirical foundations on which to lobby for, as well as sustain men-centered programs.

Conclusion

In connecting masculinities to men's work-related depression and suicide amid highlighting some targeted mental health promotion programs, the authors confirm the need to understand gender as plural, relational, multidimensional, and deeply contextual (Johnson & Repta, 2012). That said, in terms of structure and agency, operationalizing gender, work, and men's mental health in the aforementioned ways reveals significant complexities and challenges. Specifically, crumbling economic structures that are increasingly troubled to provide work opportunities and adequately reward current workers have emerged

alongside prevailing masculine ideals that define and privilege (or punish) men according to what they do and how much they earn. On the surface, resolving this structure agency discord might require (a) corrections to restore structures that afford paid work opportunities to all men and (b) the empowerment of men to [re]define their masculine capital and what it means to be a man outside the specific domains of paid work, career, and remuneration. However, as history has shown men's vulnerabilities for depression and suicide are heightened in circumstances akin to the current economic uncertainty, in large part (Berk, Dodd, & Henry, 2006; Gunnell, Platt, & Hawton, 2009), because of the mismatch between weakened masculine structures and high expectations for male agency. In conclusion, at this point in time, it seems entirely reasonable, if not imperative, to focus on promoting the mental health of men who are in as well as of those out of work.

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