

Primary Care, Males, Masculinity, and Suicide: A Grounded Theory Study

John Thomas Casey, PhD, MSW
Portland State University
Portland, OR

Statement of the Research Problem

Suicide completion in the United States is a public health problem that claims over 30,000 lives annually (Center for Disease Control, 2004). Males in the U.S. complete suicide approximately four times more often than females, yet the prevalence rate of major depressive disorder for women is roughly twice the rate for men (Ohayon, 2000; et al.). It has been found that the vast majority of suicides occur among individuals experiencing episodes of major depression (Coryell and Young, 2005), while some studies suggest that as many as 70% of suicide deaths are linked to cases of untreated depression (Lewis, 2001), with more than 65% of initial attempts resulting in completions (Rihmer, 2007). Other studies estimate that 90% of suicide victims have diagnoses of depression and/or alcohol abuse or dependence at the time of the suicide (Gaynes, et al., 2004).

Treatment of depression within the health care system is done mainly by primary care providers (PCPs) rather than in the specialty care area of mental health (Van Voorhees, 2003). The rate of male depression is likely under-reported, partly due to gender-bias within primary care and also due to the lack of gender-specific assessment instruments and interventions. Seelig and Katon (2008) assert that depressed patients may be misdiagnosed approximately 50% of the time, and they also report that the rate that primary care patients drop out of related treatment is as high as 40%. There is some evidence that many PCPs do not adequately address depressive disorders or other related diagnoses (Pincus, et al., 2001). Chan and colleagues (2006) report, for example, that major depressive disorder was identified by PCPs as a problem in the initial screening examination in only 30%-40% of depressed patients, and in only 9% of cases in which there was a co-morbid substance disorder.

In their meta-analysis related to the treatment of depression within general medical settings, Goldman, Nielsen, and Champion (1999) report that 50% to 70% of

patients who are depressed initially express somatic complaints rather than concerns about depression. They also report that PCP skill deficits and negative attitudes regarding depression contribute to treatment barriers encountered by depressed patients, with the treatment provided falling short of best practice standards. One variable that may contribute to under-treating severely depressed primary care patients, particularly the elderly, is the reticence among some PCPs to ask about suicidal ideation due to liability concerns related to the identification of that problem, or the fear that asking about suicidal ideation might encourage those thoughts (Schulberg, et al., 2004). Unfortunately, the assessment of acute suicidal risk within primary care is not addressed in depth in either the depression guidelines for primary care or the research literature, and the knowledge and use of screening instruments that can identify that level of risk is quite limited, leaving PCPs with little ability to safely manage acutely suicidal patients (Gaynes, et al., 2004).

It may be the case that some methods used to assess depression in males are not sensitive to male-specific characteristics of depression, such as increased alcohol use (Kuehn, 2006). Cochran and Rabinowitz (2003) suggest that "...undiagnosed and untreated depression in men may be one reason why many more men than women commit suicide" (p. 132). They also delineate a comprehensive depression assessment format that includes but expands upon DSM-IV criteria in areas of "masculine-specific" symptoms, such as anger outbursts, and increased use of alcohol and other substances. Norman (2004) suggests that men's depression is often masked by alcohol and drug abuse, while women may be more likely to report feelings of hopelessness and lack of confidence, in part reflecting their experience of gender oppression. More generally, she also finds that the prevalence rate for depression is culturally skewed by gender differences in help-seeking behaviors and the reporting of symptoms, with women in the U.S. more likely than men to ask for help and to be prescribed antidepressant medication. And even though the prescription of antidepressant medications increased 147% between 1990 and 1998 (Goldstein and Rosselli, 2003), antidepressants were prescribed by PCPs for less than only a third of markedly depressed patients (Goldman, Nielsen, and Champion, 1999).

Research Background and Hypotheses

Miller, et al., (2007) report that 80% of all suicide deaths in the U.S. involve males and that 88% of male suicides involve the use of firearms. A study by Joe, Marcus, and Kaplan (2007) explores the relationship between the completion of suicide by firearm and numerous variables, and finds that 78% of the decedents had not been taking antidepressant medication prior to their death and 84% had not been involved in mental health treatment, leading to their recommendation that PCPs discuss suicidal risk with their patients.

It is proposed here that the higher rate of suicide completion among males reflects to some extent differences in males' experience of depression, as compared to females', and that males face certain barriers to getting help for their depression, which then increase both symptom severity and the risk of suicide. An underlying premise of this study is that gender identity is a social construction that for many males impedes their ability and willingness to ask for help if in so doing their core sense of self is threatened. While there are gender-role expectations for both males and females that are consistent with the constructs of masculinity and femininity, respectively, there are elements of masculinity that may uniquely contribute to the high rate of suicide completion among males.

Mahalik (1999) has proposed that masculinity involves a socialization process in which a gender-role schema is taught to males at an early age in a very direct manner. He further postulates that the schema is quickly internalized and then reinforced throughout the life span via eight main scripts provided to males, which he has identified as the pursuit of success, power, emotional control, fearlessness, self-reliance, primacy of work, playboy, and disdain of homosexuals. That collection of scripts, or messages, constitute various elements of the primary/traditional masculine gender-role expectations which are commonly maintained at the expense of males' emotional connection with themselves and with others.

The influence of parents, peers, teachers and the mainstream media contribute to the ongoing social construction of masculinity, which invariably leads many males to experiences of gender-role conflict or strain when their feelings or accomplishments are at odds with traditional gender-role expectations (Mahalik, et al., 1998). Gender-role strain, according to Levant (1996), reflects the lack of a universal model of masculinity, which is elusive because the definition of an ideal gender-role for men varies somewhat according to several factors such as class, age, sexual orientation, and race. This may best be exemplified by differences in how gay males and heterosexual males develop a sense of masculine identity within the context of our culture's set of gender-role expectations. Men who feel conflicted about their inability to meet any given social definition of masculinity are more likely to be at risk of depression, substance abuse, and an inclination to act out in terms of anger and high-risk behaviors (Mahalik, 1999), all of which are variables that have been shown to be associated with suicide completion. The prevailing male gender-role, according to Moller-Leimkuhler (2003), reflects the value within Western culture for toughness in men through the characteristics of competitiveness, aggression, dominance, and independence, which often preclude the possibility of seeking help when it is needed.

Help-seeking behaviors were explored by Sleath and Rubin (2002) who found that females initiated a discussion regarding depression with their PCPs 62% of the time, while in the case of males it was the PCP who first raised that topic for discussion 67% of

the time, with patients more than three times as likely to be counseled if the PCP was female rather than male. It has been reported in another study that patients being treated for anxiety were more likely to be counseled by female PCPs than by male PCPs (Chan, et al., 2006). These studies suggest that there may be a reciprocal male gender-role expectation within primary care practice in which it may be out of character for many male patients to report feelings of depression, especially to a male PCP.

Accurately assessing depression and evaluating suicidal risk in the primary care setting is crucial, regardless of age or gender, given the finding in one study that among individuals reporting suicidal ideation, 87% had seen their PCP within the last year one or more times (Brook, et al., 2006). A qualitative study by Nirui and Chenoweth (1999) involving suicide survivors, though, suggests that suicide decedents had been uncomfortable confiding in their PCPs and/or not confident that their concerns would be received in a supportive manner or effectively dealt with. Luoma and colleagues (2002) reviewed 40 studies conducted to determine rates of contact that suicide decedents had with either primary care or mental health services prior to their death, and they found a much higher rate of contact in primary care. More specifically, they found higher rates of contact in primary care within one year (75%) and within one month (45%) prior to suicide completion, as compared to rates of 33% and 20%, respectively, for mental health services.

It has been shown that gender plays a role in the diagnosis of depression by PCPs, with females more likely to be diagnosed with depression than males, even when symptoms and severity are similar, as evidenced by high scores on the Beck Depression Inventory (BDI) for both genders (Bertakis, et al., 2001). In that same study, marital status did not influence the diagnosis of depression in males, but females were approximately five times more likely to be diagnosed with depression if they were divorced, separated, or widowed, as compared to those who had never married. These findings suggest that while the assessment of depression in females may be fairly accurate within primary care, there appears to be a bias within primary care to not see males as being depressed, even when reliable instruments such as the BDI are used. Other studies regarding medical necessity (Sabin and Daniels, 1994; Schwartz and Weiner, 2003) speak to PCPs' considerable challenges to see a high volume of patients while also keeping the cost and scope of care to a minimum, perhaps further limiting PCPs' responses to their patients' depression and suicidality.

Methodology

Given that the completion of suicide precludes follow-up studies of subjects, suicide research is largely dominated by quantitative studies of epidemiology, along with retrospective studies, such as psychological autopsies. In an effort to complement those

efforts, the present study is situated within the context of primary care practice, where most cases of depression are treated. This study utilized a grounded theory approach to interpret the phenomenon involving the subjective experience that PCPs have in their routine assessment of patients who may be depressed and may also be at risk of suicide. A grounded theory study involving PCPs is pursued here because there are no known studies that offer insight into the role that the PCP-patient relationship plays in the effort to intervene in the pathway that many individuals follow from depression to death.

Grounded theory arose from the field of sociology in the 1960s, and it involves the study of a phenomenon through an inductive process that results in the emergence of a relevant theory (Strauss & Corbin, 1990). It strives for an enhanced understanding of the human experience through a process designed “to explain a given social situation by identifying the core and subsidiary processes operating in it” (Baker, Wuest and Stern, 1992, p.1357). The essential elements of grounded theory include participant selection that reflects emerging hypotheses, simultaneous research processes, and a focus on the usefulness of the findings rather than the validity of the findings (Maggs-Rapport, 2000). Unlike quantitative studies, which test hypotheses that reflect research questions, grounded theory studies begin with the articulation of a research problem and related research questions, and then move into the process of data collection which ultimately yields a theory that is grounded in the data (Charmaz, 2006).

As conceptualized by Strauss & Corbin (1990), conducting a grounded theory study involves doing fieldwork to gather data, such as the PCP interviews in this study, and then simultaneously coding the data and testing theories that emerge from the data. Grounded theory was chosen for this study because the area of interest here is PCPs’ subjective experience of treating males for depression and suicidality, and the interpretative approach of this methodology can best capture the PCP perspective while also facilitating the construction of a related theory.

An important distinction regarding methodology is offered by Caelli (2001) who notes that “*Methodology* refers to the philosophical framework that must be assimilated so that the researcher is clear about the assumptions of the particular approach, whereas *method* refers to the research technique and the procedure for carrying out the research” (p. 275, emphasis in original). Charmaz (2006) considers the methods of a grounded theory approach to be “a set of principles and practices, not as prescriptions or packages...[that can be thought of as] flexible guidelines, not methodological rules, recipes, and requirements” (p. 9). Her interpretation of grounded theory methodology and methods has guided the design and execution of this study.

An advantage of utilizing grounded theory methods in this study is that the simultaneous construction and analysis of data throughout the study generated a theoretical basis for more fully understanding the PCP-patient relationship as it pertains to the treatment of depression (Charmaz, 2006). Within the semi-structured interview

format utilized in the study there was the flexibility to have some dialog with participants and ask different questions in any given interview, while also asking all participants a core group of questions. The specific areas of inquiry in this study are consistent with a defining characteristic of research questions from a grounded theory approach, which is that they generally involve some type of action and process, and address interactional, organizational, or biographical dynamics (Strauss & Corbin, 1990). Those types of questions can be found within the scripted questions in the present study, which explore participants' relationships with depressed patients (interactional), the PCPs' various styles of managing the time pressures inherent in primary care practice (organizational), and the past experiences that PCPs have had in treating depressed/suicidal patients (biographical).

Results

The main objective of this study was to gain an understanding of the patient-provider relationship from the PCPs' perspective within the context of clinical practice as it pertains to treating patients for depression, and managing suicidal risk. Within the specific area of suicide risk assessment, there was a broad range of responses, including this candid comment from a participant who says "I'm out of my league with somebody who I think is, you know, really suicidal or whatever, because I'm certainly not an expert at dealing with people." A possible implication of this statement is that this PCP's sense of identity involves being an expert in the area of physical systems and illnesses, rather than in the area of relationships per se. This is very different than social workers' sense of professional identity, which does include being an expert in the area of relationships.

On the opposite end of the continuum, the following response from another participant demonstrates a high level of both competence and confidence in this most critical area of intervention:

I'll come right out and ask them, are you thinking of hurting yourself, have you ever thought of hurting yourself, have you ever hurt yourself or tried to, um, so that's a pretty standard question for everybody. Um, I'll ask about firearms in the home and impulsivity, you know, do you have thoughts, just even for a second [snaps fingers], that you don't want to be here, and, um, you know, ask about their family history of depression or suicide. I'll ask them if when they're drinking or when they're high, do you feel more suicidal at that time or more likely...I'll just ask if you're thinking of hurting yourself or killing yourself...If they answer that they have guns in the home I ask them to lock it up if it's not locked up.

In yet another example, this next participant suggests both a lack of competence in assessing suicidal risk, and also a fairly low level of confidence in this area.

I don't have, um, I probably don't do a very good job of that, have a systematic way, I usually just flat out ask them, you know, have you had any suicidal thoughts... I don't really know what other doctors do but I think they do a better job than me in really checking it out...I just sort of drop it and move on...I would think most of the doctors in this clinic feel very comfortable, I certainly feel comfortable, I don't know that I, you know, pick up on it [suicidality] and treat it right but I feel like I know what I'm doing whether I do or not.

Although the 16 interviews were conducted with a semi-structured interview guide, they were varied and wide-ranging in content, such as in the transcripts cited above. Study participants otherwise described two clinical styles, which involved either relying mainly on the use of formal assessment instruments during the standard-length office visit, or on longer in-depth clinical interviews in which more background information is gathered. Several of the participants spoke to their experience of the contrast between the reluctance of males to see themselves as depressed, in contrast to the relative ease with which females report their depression to their PCPs. More generally, there was among the PCPs varying levels of awareness of and sensitivity to the deficits in help-seeking behaviors common among many male patients, and it appears that it is the PCP's philosophy of treatment that most clearly influences how they respond to that dilemma.

Two key themes emerged through the data coding process and each was supported by several relevant subcategories. The first theme, *Gender Differences Within the Assessment Process*, is comprised of the following subcategories; *problem identification, depression assessment, suicidal risk, masculinity issues, stigma, and relationship with patient*. The second key theme, *Style of Clinical Practice*, includes the subcategories; *methods of assessment, risk assessment, engagement style, sense of community and use of behavioral health professional*. Through the analysis of these subcategories it is apparent that the patient's experience of treatment is likely influenced by the provider's practice style, and it was also found that there is considerable variability within that style.

A sense of mutual connection within the patient-provider relationship forms the basis of the grounded theory that evolved from the data, Relationship-Based Medicine (RBM), which is also supported by the two main themes generated by the study. Those themes in combination delineate an approach to primary care practice that can be seen both as an alternative to the more traditional medical model, and as a model that can considerably enhance the assessment and treatment of depression and suicidality. An essential element of RBM is a commitment to create the time and emotional space needed to facilitate long-term relationships with patients, despite the onerous time pressures inherent in primary care practice. It may also be the case that there may be more

potential to treat depressed males in primary care because there is less stigma associated with that setting, as compared to being seen through the department of mental health.

While there is a natural overlap between the two models, given that both involve the provision of medical care to patients through a patient-provider relationship, often of long term duration, it is the mutual sense of community with patients that most clearly differentiates RBM from the medical model. A second distinguishing feature of the RBM focus is the practice of conducting in-depth clinical interviews to comprehensively assess the areas of depression and suicidality, rather than using standardized assessment instruments. Support for the RBM model can be found in a study by Baik and co-authors (2005) who found that PCPs diagnose depression sooner and more accurately when they spend the time it takes to get to know their patients and when they have an emotional connection with them.

Further support for the proposed RBM model can be found in the work of Scott, et al. (2008), who developed a model that fosters healing relationships within primary care practice. Among other variables, they found that both patients and PCPs had a stronger sense of the healing process when they had an experience of mutual connection, and when PCPs were able to spend sufficient time to develop long term relationships with patients. Miller and colleagues (2003) identified attributes that facilitate healing relationships, which they say include trust, closeness and emotional engagement within the patient-provider relationship. In a similar manner, Brody's review of patient-centered care (2006) is predicated on the premise that the quality of the PCP-patient relationship comprises the core of family practice, a distinction that he says is unique among all other areas of medical specialty.

This study suggests that RBM offers more opportunity to engage males in primary care treatment than the medical model, although there are also indications that there are gaps in the ability within both approaches to effectively and safely manage depressed patients with higher acuity and higher risk for suicide. Limitations of the medical model include its reductionistic focus on the linear process of assessing symptoms, diagnosing disorders and prescribing treatments from a logical positivist perspective that limits subjectivity and engagement (Freeth, 2007). Boyle (2006) suggests that developing alternatives to the medical model is a daunting challenge given its ideological power, and she maintains that the biopsychosocial model is one example of an attempt that failed because of its roots in biological influences, despite its attempt to focus on psychosocial factors.

Regardless, PCPs of both persuasions commonly expressed a lack of confidence in their ability to adequately assess suicidality among their patients, ranging from those who appeared to have very good skills in this area despite their disclaimers to the contrary, to those who either did not pursue this level of assessment or made little attempt to do so. The outcome of this study otherwise basically reflects two very different

approaches to the assessment and treatment of depression and suicidality within the four primary care settings where the participants were interviewed. While there are some elements common to both models, the RBM and medical model styles of practice appear to be mostly polar opposites, and there is no indication that a convergence of those approaches is likely unless some type of formal structure to support it is developed.

Utility for Social Work Practice

This study is influenced by the premise that social workers are specifically trained to assess broader environmental factors that impact individuals, such as gender role issues and alienation within our culture. An area of particular interest here is the PCPs' style of assessment, compared to how social workers approach that element of the clinical encounter. In addition to the delineation of the RBM style of primary care practice, there is also within this study an outline of an approach to the treatment of depression and suicidal risk that involves more collaboration between primary care and mental health providers. It is suggested that further integration of those two disciplines/professions can be enhanced by the efforts of social workers because of their mental health training and expertise, along with their focus on system needs, challenges and resolutions.

Although the location of therapists within primary care settings involved in this study is limited to just a few clinics at present, it is an example of how social work can assert a position and a presence within healthcare systems. An example of a successful expansion of psychiatric social worker presence in primary care on a larger scale can be found in a study involving the Grand Valley Health Plan in Michigan, which found that collocating mental health therapists within primary care led to a 54% decrease in psychiatric hospitalization (Van Beek, et al., 2008). Collocating psychiatric social workers within primary care, along with more emphasis on the RBM model offers a framework, and some hope, for males to have the opportunity and support to construct a new model of self-care that promotes healing, and in the process helps reduce suicidal risk for depressed patients.

Even though the PCPs at the clinics where interviews were conducted have access to emergency psychiatric services, it seems from their input that they have the sense that neither their training nor their experience equips them with the skills to effectively treat acute depression and suicidality. Seelig and Katon (2008) speak to this bind in their observation that the "Perceived usefulness of obtaining mental health specialty consultation impacts primary care physician reliance upon these potential colleagues and ultimately likely plays a role in whether patients receive appropriate, effective treatment"(p. 455). Their point would seem to suggest that providing primary care with enhanced resources from the department of mental health merits consideration. In addressing the limitations of the medical model more broadly from the perspective of social work practice, Kane (1986) concurs that "Integration—not polarization—of health and social services is sorely needed" (p. 315).

The field of social work, through its person in environment (PIE) framework, also provides a perspective through which suicide completion could be examined to better understand the context within which it occurs. Karls and co-authors (1997) describe PIE as a four-factor system that is designed to facilitate social work assessment and intervention regarding difficulties in an individual's functioning and environment within the context of mental and physical health challenges. Given that many depressed males can be seen as having deficits in the language of emotion, it is perhaps as important to understand their experience of alexithymia as it is to understand the environment that fosters it. Karls and Wandrei (1992) suggest that while the use of the PIE approach will not replace the DSM in terms of diagnosing psychiatric disorders such as depression, it "will allow social workers to systematically conceptualize and describe clients' problems in the language of social work" (p. 85), thus enhancing the opportunity for social work intervention. There is also support for the ability of social work to provide primary care practice with a unique perspective of mental health issues within their contention that "Much of social work's contribution to the helping profession centers on the strengths and resources a client brings to a problem situation. Social work as a profession has diligently resisted a medical, disease-oriented model for describing and classifying client problems" (p. 81).

Beyond PIE, social work research also has a strong focus on the voice of the client. In her review of service design and delivery for the elderly, Powell (2007), for example, explores the contribution of social work both within that client population, and within the area of social research and related multi-disciplinary interventions. She asserts the position that social work is well positioned to help elderly individuals have more voice in the change process through their participation in qualitative studies that focus on their needs and challenges. Powell also notes that while those methodologies are "not unique to social work research, such methods can be distinctive or characteristic of research that is committed to listening and making explicit the voice or lived experience of those involved in the research process" (p. 113). The voice of depressed males is not well represented in the literature, which may in some respects mirror the deficits in the language of emotion that characterize the social construction of their gender-role expectations. Within that vein, Levant, et, al. (2003) posit that "one of the central premises of the social constructionist perspectives on gender is that there is no invariant masculinity (in the case of men) but rather there are 'masculinities' that vary according to the social context" (p. 92).

The context of the present study is that males in the United States, usually rather silently, take their own lives at a rate that would very likely evoke an outcry for immediate intervention if it posed a threat to others. In absence of that threat, it is proposed here that social work has a responsibility to advocate for the voice of depressed males to be heard, unfettered by the force of toxic gender-role constrictions. Social workers are well prepared to articulate those concerns through what Bloom and

colleagues (1991) outline as the six languages of social work, which involve a fluency in the voice of “the client, the abstract language of the theorist, the empirical and often quantitative language of the researcher, the categorical language of the information scientist, the technological terminology or jargon...as used by helping professionals, and the preferential language that conveys values” (p. 530).

And just as there is a particular language common to primary care medicine, such as terms related to organs and procedures, there is also a language that is common to mental illness and suicide. After the suicide death of her son, who was a gifted physician despite having a bipolar disorder, Sommer-Rotenberg (1998), for example, takes exception to the expression “committed suicide,” which is commonly used in reference to a death due to suicide. She speaks to the pejorative nature of that term by noting that “The only acts we ‘commit’ are heinous ones: adultery, a felony, some kind of crime” (p. 239), and she challenges physicians to “send a powerful message to colleagues, patients and society at large by using neutral and compassionate language when they refer to suicide” (p. 240). Social work has the ability, if not the obligation, to promote a new language of suicide by using terms such as “suicide completion” and “suicide decedents,”

so that others too may begin to shift their language, and thereby lessen the stigma and shame that is so often associated with depression and suicide.

References

- Baik, S-Y., Bowers, B. J., Oakley, L. D., & Susman, J. L. (2005). The recognition of depression: The primary care clinician's perspective. *Annals of Family Medicine*, 3(1), 31-37.
- Bertakis, K. D., Helms, L. J., Callahan, E. J., Azari, R., Leigh, P., & Robbins, J. A. (2001). Patient gender differences in the diagnosis of depression in primary care. *Journal of Women's Health & Gender-Based Medicine*, 10, 689-698.
- Bloom, M, Wood, K., & Chambon, A. (1991). The six languages of social work. *Social Work*, 36(6), 530-534.
- Boyle, M. (2006). Developing real alternatives to medical models. *Ethical Human Psychology and Psychiatry*, 8(3), 191-200.
- Brody, H. (2006). Family medicine, the physician—patient relationship, and patient—centered care. *The American Journal of Bioethics*, 6(1), 38-39.
- Brook, R., Klap, R., Liao, D., & Wells, K. B. (2006). Mental health care for adults with suicide ideation. *General Hospital Psychiatry*, 28, 271-277.
- Caelli, K. (2001). Engaging with phenomenology: is it more of a challenge than it needs to be? *Qualitative Health Research*, 11(2), 273-281.
- Center For Disease Control. (2004). *Fatal injury reports*. Retrieved May 10, 2007, from CDC homepage via <http://www.cdc.gov/ncipc/wisqars/>.
- Chan, K. S., Bird, C. E., Weiss, R., Duan, N., Meredith, L. S., & Sherbourne, C. D. (2006). Does patient-provider gender concordance affect mental health care received by primary care patients with major depression? *Women's Health Issues*, 16, 122-132.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Thousand Oaks: Sage Publications.
- Cochran, S. V., & Rabinowitz, F. E. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men. *Professional Psychology: Research and Practice*, 34(2), 132-140.
- Coryell, W., & Young, E. A. (2005). Clinical predictors of suicide in primary major depressive disorder. *Journal of Clinical Psychiatry*, 66, 412-417.
- Freeth, R. (2007). Working within the medical model. *Therapy Today*, 18(9), 31-34.
- Gaynes, B. N., West, S. L., Ford, C. A., Frame, P., Klein, J., & Lohr, K. N. (2004). Screening for suicide risk in adults: A summary of the evidence for the U.S. preventive services task force. *Annals of Internal Medicine*, 140(10), 822-835.

- Goldman, L. S., Nielsen, N. H., & Champion, H. C. (1999). Awareness, diagnosis, and treatment of depression. *Journal of General Internal Medicine*, 14(9), 569-580.
- Goldstein, B., & Rosselli, F. (2003). Etiological paradigms of depression: the relationship between perceived causes, empowerment, treatment preferences, and stigma. *Journal of Mental Health*, 12(6), 551-563.
- Joe, S., Marcus, S. C., & Kaplan, M. S. (2007). Racial differences in the characteristics of firearm suicide decedents in the United States. *American Journal of Orthopsychiatry*, 77(1), 124-130.
- Kane, R. A. (1986). Lessons for social work from the medial model: A viewpoint for practice. *Social Work*, July, 315-321.
- Karls, J. M., Lowery, C. T., Mattaini, M. A., & Wandrei, K. E. (1997). The use of the PIE (person-in-environment) system in social work education. *Journal of Social Work Education*, 33(1).
- Karls, J. M., & Wandrei, K. E. (1992). PIE: a new language for social work. *Social Work*, 37(1), 80-85.
- Kuehn, B. M. (2006). Men face barriers to mental health care. *Journal of the American Medical Association*, 296(19), 2303-2304.
- Levant, R. F. (1996). The new psychology of men. *Professional Psychology: Research and Practice*, 27(3), 259-265.
- Levant, R. F., Richmond, K., Inclan, J. E., Heesacker, M., Majors, R. G., Rossello, J. M., & Rowan, G. T. (2003). A multicultural investigation of masculinity ideology and alexithymia. *Psychology of Men & Masculinity*, 4(2), 91-99.
- Lewis, L. (2001). The role of mental health patient organizations in disease management. *Disease Management Health Outcomes*, 9(11), 607-617.
- Luoma, J. B., Pearson, J. L. (2002). Suicide and marital status in the United States, 1991-1996: Is widowhood a risk factor? *American Journal of Public Health*, 92(9), 1518-1522.
- Mahalik, J. R. (1999). Incorporating a gender role strain perspective in assessing and treating men's cognitive distortions. *Professional Psychology: Research and Practice*, 30(4), 333-340.
- Mahalik, J. R., Cournoyer, R. J., DeFranc, W., Cherry, M., & Napolitano, J. M. (1998). Men's gender role conflict and use of psychological defenses. *Journal of Counseling Psychology*, 45(3), 247-255. .
- Miller, M., Lippmann, S J., Azrael, D., & Hemenway, D. (2007) *Journal of Trauma, Injury, and Critical Care*, 62(4), 1029-1035.

- Miller, W. L., Crabtree, B. F., Duffy, M. B., Epstein, R. M., & Stange, K. C. (2003). Research guidelines for assessing the impact of healing relationships in clinical medicine. *Alternative Therapies*, 9(3), 80-95.
- Moller-Leimkuhler, A. M. (2003). The gender gap in suicide and premature death or: why are men so vulnerable? *European Archives of Psychiatry and Clinical Neuroscience*, 253, 1-8.
- Nirui, M., & Chenoweth, L. (1999). The response of healthcare services to people at risk of suicide: a qualitative study. *Australian and New Zealand Journal of Psychiatry*, 33, 361-371.
- Norman, J. (2004). Gender bias in the diagnosis and treatment of depression. *International Journal of Mental Health*, 33(2), 32-43.
- Ohayon, M. M. (2000). Comorbidity and treatment consequences. *Canadian Journal of Psychiatry*, 45(2), 166-172.
- Pincus, H. A., Hough, L., Houstsinger, J. K., Rollman, B. L., & Frank, R. G. (2001). Emerging models of depression care: multi-level ('6 P') strategies. *International Journal of Methods in Psychiatric Research*, 12(1), 54-63.
- Powell, J. (2007). Promoting older people's voices. *Social Work in Health Care*, 44(1), 111-126.
- Rihmer, Z. (2007). Suicide risk in mood disorders. *Current Opinion in Psychiatry*, 20, 17-22.
- Sabin, J. E., & Daniels, N. (1994). Determining "medical necessity" in mental health practice. *Hastings Center Report*, 24(6), 5-15.
- Schulberg, H. C., Hyg, M. S., Bruce, M. L., Lee, P. W., Williams, J. W., & Dietrich, A. J. (2004). Preventing suicide in primary care patients: The primary care physician's role. *General Hospital Psychiatry*, 26, 337-345.
- Schwartz, J., & Weiner, M. B. (2003). Finding meaning in medical necessity. *Social Work*, 48(3), 392-401.
- Scott, J. G., Cohen, D., DiCicco-Bloom, B., Miller, W. L., Stange, K. C., & Crabtree, B. F. (2008). Understanding healing relationships in primary care. *Annals of Family Medicine*, 6(4), 315-322.
- Seelig, M. D., & Katon, W. (2008). Gaps in depression care: Why primary care physicians should hone their depression screening, diagnosis, and management skills. *Journal of Occupational and Environmental Medicine*, 50(4), 451-458.
- Sleath, B., & Rubin, R. H. (2002). Gender, ethnicity, and physician-patient communication about depression and anxiety in primary care. *Patient Education and Counseling*, 48, 243-252.

- Sommer-Rotenberg, D. Suicide and language. (1998). *Canadian Medical Association Journal*, 159(3), 239-240.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded Theory Procedures and Techniques*. Newbury Park: Sage Publications, Inc.
- Van Beek, K., Duchemin, S., Gersh, G., Pettigrew, S., Silva, P., & Luskin, B. (2008). Counseling and wellness services integrated with primary care: A delivery system that works. *The Permanente Journal*, 12(4), 20-24.
- Van Voorhees, B. W., Cooper, L. A., Rost, K. M., Nutting, P., Rubenstein, L. V., Meredith, L., Wang, N-Y., & Ford, D. E. (2003). Primary care patients with depression are less accepting of treatment than those seen by mental health specialists. *Journal of General Internal Medicine*, 18, 991-1000.