A Qualitative Investigation of Depression in Men

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This study employed grounded theory methodology to analyze men’s’ descriptions of their experiences of depression. The sample included 15 male participants between the ages of 24 and 75. After completing a brief screening process, participants attended an interview lasting between 45 and 90 minutes. Eight participants attended follow-up interviews lasting between 15 and 45 minutes. Interview questions were developed by a six-member research team and were designed to elucidate the participants’ signs and symptoms of depression, their help-seeking processes, and their experiences with treatment and recovery. Results yielded 10 primary themes that captured the distinct ways the men identified, experienced, and managed their depression. A model for men’s experiences of depression was developed. The results of this study are discussed in the context of existing research on depression in men. Recommendations for future research on men’s depression, as well as suggestions for clinical practice with men are also presented.

Keywords: men, masculinity, depression, help seeking, grounded theory

Major depression is a central concern for both scholars and clinicians. Using data from the National Comorbidity Survey, Kessler, McGonagle, Swartz, Blazer, and Nelson (1993) reported that the lifetime rate of major depressive episode among men was 12.7%, while the rate for women was 21.3%. A more recent National Comorbidity Survey Replication found almost identical lifetime prevalence rates of major depressive disorder: 13.2% for men and 22.5% for women (Kessler et al., 2003). Based on these findings, almost one in five Americans may expect to suffer a major depressive episode at some point in their lifetime.

Investigators have speculated on what could account for the discrepancies in measured rates of major depression between men and women. For example, Cochran and Rabinowitz (2000) argued certain behaviors of depressed men could obscure the measured rates of depression. These behaviors include displaying anger or aggression when depressed and self-medicating with alcohol. Additionally, Moller-Leimkuhler, Bottlender, Straub, and Rutz (2004) found no gender differences in frequencies of irritability, aggressiveness, and antisocial behavior in a sample of 2,411 inpatients diagnosed with unipolar depression. However, a factor analysis of participants’ responses revealed that these behaviors were more strongly correlated with depression in men than women.

Another explanation for the discrepancy in rates of depression may be that the traditional diagnostic criteria for major depression represent an inward, feminine congruent coping process not characteristic of men (Kilmartin, 2005). Studies on gender bias in diagnosis of depression have determined that when measurement criteria are augmented with gender-fair items, it is possible to detect more men with depression (e.g., Angst & Dobler-Mikola, 1984; Murphy, Olivier, Monson, Sobol, & Leighton, 1988). In this vein, Pollack (1998) has proposed criteria for major depressive disorder-male type. Some of the proposed criteria include a tendency to become over involved with work activities, avoidance of help, an increase of angry outbursts, and denial of sadness.

To circumvent the limitations encountered in applying traditional definitions and measurement models to study men’s depression, Cochran and Rabinowitz (2000) recommended the
use of qualitative methodologies. Studies using qualitative approaches may provide opportunities for in-depth exploration of men’s lives. This exploration may illuminate aspects of men’s experiences of depression and the manner in which depression is expressed that are not captured when utilizing traditional methodologies, definitions, or measurement strategies.

Heifner (1997) utilized grounded theory to study the experiences of 14 depressed men. Among the participants, she found a rigid adherence to traditional gender roles, anxiety attached to work performance, emotional distance from others, hiding of emotions, substance abuse, a reluctance to enter therapy, and suicide viewed as a means of gaining control. Brownhill, Wilhelm, Barclay, and Schmied (2005) also used grounded theory methodology to analyze group discussions focused on exploring characteristics of men’s depression. These group discussions were attended by a nonclinical sample of 77 teachers and students. The participants described a process they termed a big build in which negative emotions (e.g., sadness, emptiness, and anger) intensified in men through suppressive, as opposed to expressive, methods of coping. The suppressive coping methods led to expressions of depression that would not be present in clinical settings and included impulsive risk-taking, withdrawal, and escalating substance abuse. Finally, Danielsson and Johansson (2005) interviewed 18 patients in a Swedish health care center to explore gendered formulations of experiences with depression. They found that men readily externalized or somaticized distress while women verbalized responses to depression. While these three studies advanced our understanding of men’s depression in various ways, they are limited in that they utilized restrictive, inpatient populations (Danielsson & Johansson, 2005; Heifner, 1997) or nonclinical samples of community members who were simply asked to discuss their impressions of men’s depression (Brownhill et al., 2005).

In light of the limitations identified in these qualitative investigations, additional studies that focus on men’s depression are warranted. Therefore, the purpose of this study was to employ qualitative methodology for an in-depth exploration of men’s experiences of depression. Grounded theory (Fassinger, 2005; Strauss & Corbin, 1990) was chosen as the avenue by which to explore men’s experiences of depression since it emphasizes the complex nature of individuals’ lived experiences in a social context and yields an understanding of the phenomenon under study that is grounded in the participants’ narratives of their experiences.

Method

As noted, this investigation utilized a grounded theory methodology. Fassinger (2005) recommended detailed descriptions of the research team involved in the study and of the procedures used for gathering and coding participant interview narratives. This section will describe in detail the research team, the process by which the team designed the procedures for and conducted data collection, the research participants, and the manner in which the data was analyzed.

Research Team

The research team was comprised of one 57-year-old Caucasian male licensed psychologist and five graduate students (four males and one female) between the ages of 26 and 37 from a doctoral program in counseling psychology at a Midwestern university. All five graduate students were Caucasian and were from middle to upper-middle class socioeconomic backgrounds. All research team members had previous academic and employment experience within psychology and specifically in the study of men and masculinity. Based on these backgrounds, research team members were aware of the gaps in research on men’s depression. Over the course of the research project the research team engaged in a reflexive analysis of individual team members’ understandings, biases, and assumptions with regard to men’s depression. Such analysis mitigated the influence of individual team members’ biases in the development of project goals, research questions, and analysis of the participant interview narratives.

The research team met weekly to discuss gender differences in the rates and expression of depressive symptoms and various methodologies that have been utilized to study men’s depression. Models of depression, such as the rumination—distraction response styles model (Nolen-Hoeksema, 1990, 2001), the self-medication model (Gilman & Abraham, 2001;
Khantzian, 1985), and the masked depression model (Cochran & Rabinowitz, 2000; Lesse, 1983) were discussed and critiqued. Minutes of each weekly meeting were recorded and reviewed at the beginning of each subsequent meeting.

**Procedures**

Participants were recruited by advertisements placed in a local hospital newsletter and at various locations around the community. These locations included grocery stores, buses, and community bulletin boards in local retail stores. A heterogeneous group of participants from the community was sought to address the limitations of participant homogeneity in previous qualitative studies of men’s depression. The recruitment advertisement was worded: “Have you ever been treated for depression? Are you willing to participate in a research project studying men’s experience with depression? Men who have been treated for depression are invited to participate in a study on depression in men.”

All potential participants who responded to the advertisements were screened by phone by one of the research team members. Eligible participants included men between the ages of 18 and 75 who had been diagnosed with and treated for depression within the prior 5 years. Prospective participants were also asked whether they had received psychotherapy, pharmacotherapy, or both, as well as what type of practitioner had been consulted. While these recruitment parameters could introduce potential confounds to the data, the primary recruitment goal was to obtain a wide sample of men who would self-identify as having been depressed and having received treatment for depression. No endorsement of any particular set of diagnostic criteria was required for enrollment.

Participation involved an initial phone screening and, if included in the study, one initial interview and one follow-up interview. Both interviews were conducted in person. The phone screening consisted of three questions: Have you ever been diagnosed with depression? At what point did you realize you might be depressed? In hindsight, were there any initial indicators you were feeling different?

<table>
<thead>
<tr>
<th>Initial Interview Questions</th>
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<tr>
<td>We would like to know about your experience with depression. Can you tell us about that?</td>
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<td>At what point did you realize you might be depressed?</td>
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<td>In hindsight, were there any initial indicators you were feeling different?</td>
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<td>P. Any specific changes in behavior?</td>
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<td>P. Any changes in your level of activity?</td>
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<td>P. Were there any changes in your professional life?</td>
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<td>P. Were there any changes in your relationships?</td>
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<td>How did you manage your depression?</td>
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<td>P. Initially address your depression?</td>
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<td>P. Resolve your depression?</td>
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<td>P. What did you do to make yourself feel better?</td>
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<td>What prompted you to get help?</td>
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<td>In what ways did a man impact your depression?</td>
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<td>How should men deal with depression?</td>
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<td>How would you recognize depression in other men?</td>
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Note. P = predetermined probing question.
follow-up interviews with participants were scheduled. The follow-up interviews with the participants occurred approximately eight months after the first interviews were completed. These interviews served a dual purpose: (1) to allow participants the opportunity to confirm the accuracy of the preliminary model of men’s depression and (2) to gain a more complete understanding of these participants’ experiences with depression. To avoid presenting incomplete data to the participants, results were not shared with participants until completion of the preliminary round of data analysis and coding was completed on all participants.

**Participants**

Thirty-eight men responded to the initial recruitment solicitation. Of these initial 38 men, 15 did not follow through with the screening process due to inadequate contact information or because the study did not provide adequate compensation. Participants who had received some form of pharmacological or psychological therapy for depression were included in the study.

One participant that completed the screening process was not included in the study because he had never been formally diagnosed with depression. Seven eligible participants did not follow through with the scheduled first interview. After completing a phone screening, a total of 15 participants completed the first interview. All 15 participants were contacted after eight months to participate in a follow-up interview. Seven participants completed this second interview. Of the eight that were not part of the follow-up, five did not respond to calls or emails, one declined to participate, and two were no longer accessible through their original contact information.

Participants were diverse in terms of education level, sexual orientation, race and ethnicity, age, relationship status and socioeconomic class. Educational levels included high school education (n = 4), some college (n = 4), college graduate (n = 4), and graduate or professional degrees (n = 3). The sample included 13 men who identified as heterosexual, one as bisexual, and one as gay. Fourteen of the participants identified as Caucasian, and one participant identified as Native American. Participants’ age averaged 44.6 years and ranged from mid 20s to late 50s, with one participant in his mid 70s. Finally, participants’ relational statuses consisted of 10 married, three partnered, and two single men. The annual salaries of the participants ranged from four who earned less than $15,000 annually to one who earned $75,000 with a majority making between $25,000 and $54,900. Although not asked about current participation in therapy all participants had sought therapy within 5 years of the beginning of the study.

All participants who completed the second interview were Caucasian. Their average age was 50 years, their education level ranged from two who completed some graduate education to three who held graduate/professional degrees. Their incomes ranged from less than $15,000 annually to a maximum of $75,000, with a majority making between $35,000 and $55,000.

**Data Analysis**

Members of the research team took turns transcribing the interviews verbatim. Transcripts were coded utilizing a grounded theory approach in three phases: open coding, axial coding, and selective coding. Open coding consisted of research team members’ review of each transcript followed by identification and delineation of themes through discussion in research team meetings. For example, although many men may experience depressive symptoms in reaction to difficult life transitions, the nature of the transition and the specifics of its impact differed for each participant. While participants’ vocational transitions might have involved job loss or job change, each transition ignited depressive symptoms that created a stressful life situation.

Following the identification of themes through the open coding process, the process of axial coding was completed. Through discussions in research team meetings, the axial coding process allowed the research team to create overarching categories or metathemes that identified relationships between themes identified in the open coding process. For example, details of men’s experiences with depression were partitioned into the categories “life transitions” and “typical depressive symptoms.” Dimensions of these categories were identified that explained the details of each category as reflected in the narratives of the participants. From these
dimensions a theory was derived and then articulated through the selective coding process.

The selective coding process classified central categories identified through the axial coding process. These central categories were based on a final discussion and review of all transcribed interviews by all members of the research team. These final central categories also guided the definition and parameters for the follow-up interviews. All 15 transcripts were coded in each of the three steps of the coding process. The coding process in the current study defined conditions in which depression is experienced by men, their effective and ineffective coping strategies, the results of their coping strategies, and how men either continue a cyclical pattern of managing their depression or depart from the cycle.

After completing the selective coding process, participants were scheduled to complete a follow-up interview which lasted between 15 and 45 minutes. During these meetings, categories that emerged from the findings were presented to the participants and feedback was received on the accuracy of the data. Questions asked in the follow-up interview included: “Does this description apply or not apply to you? How so? Do you think they apply to depressed men in general?” Participants were also asked if there were any portions of the findings that did not apply to them. Congruency between the categories and participants’ experiences with depression ensured the findings were grounded in participants’ observations and descriptions.

Results

Results revealed that these men’s experiences with depression included typical symptoms of a major depressive episode as they are described in the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition Text Revision (DSM–IV–TR; American Psychiatric Association, 2000). Results also revealed that these men had various atypical symptoms of depression that are not included in the traditional diagnostic criteria such as alcohol or substance abuse, escalating interpersonal conflict, and anger management problems. Participants’ experiences with these atypical symptoms were cyclical and escalating in nature, often representing ineffective strategies for coping with their depression. This cyclical, escalating pattern was often fueled by the men’s attempts to hide their symptoms of depression. A model was developed which depicted this cycle and the common strategies that resulted in men ending their maladaptive coping pattern (see Figure 1). Following are the 10 themes identified through the coding process along with examples taken from participant transcripts.

Transition, Adjustment, Loss

Twelve participants in this study reported a relationship between some significant change in their lives and the onset of their depression. Some of these changes related to life transitions, adjustments to these transitions, and losses, and included disruptions in the work place or geographical relocation. With the exception of three participants, these men identified some related alteration in their interpersonal relationships as the catalyst for their depression. For example, Participant 11 noted, “I was really kinda on top of the world . . . I had a lot of colleagues, lots of good relationships. Then my colleagues started taking other assignments, moving away . . . but it left me really feeling like I had nothing.”

Typical–Atypical Symptoms

These life changes, transitions, and losses of interpersonal connections triggered symptoms of depression. Participants identified symptoms typical of depression such as lack of interest in pleasurable activities, sleep disturbance, fatigue, and recurrent thoughts of death. Sadness was often implied and was described as “not feeling good” and evidenced through periods of uncontrollable crying.

While these symptoms were identified consistently across the men’s descriptions, other atypical symptoms that the men related to their depression were reflected in these same narratives. Some of these atypical symptoms included physical symptoms of stress and anger reported to be concurrent with the mood disturbance. Two-thirds of these men also identified variability in mood and periods of interpersonal disturbance as the initial indicators for their depression. For example, Participant 6 noted he was, “very irritable. I think that was the biggest thing, very irritable. Extremely stressed at work and
feeling physiological effects of the stress . . .” Similarly, Participant 13 noted, “I could have some severe mood swings, could go from being happy to having a violent behavior. I could get really mad.”

Aggravating Factors

Men also reported that their depressive symptoms were aggravated by environmental factors and by their own maladaptive reactions. For the majority of these men, further changes in the work environment escalated their mood disturbance. For all participants involved in relationships, relational discord occurred after the onset of their depression. For three men, marital discord included infidelity. Eleven men reported increased substance abuse, connecting this increase to disturbances within their families and within their workplace. Participants’ reactions to these negative environmental factors led to an escalating pattern of depression fueled by these aggravating variables. Participant 5 described this aggravation by saying, “You know,
in fact I’ve caught myself the one drinking more
and . . . you know, I guess I had an affair with
another woman.”

**Mitigating Factors**

While all the participants identified factors that aggravated their depression, they also described factors that reduced the intensity of their depressive symptoms. Access to treatment was identified by all of the participants as an important factor in mitigating depressive symptoms. Effective symptom reduction was also related to feeling as if they could safely express their feelings when they became overwhelmed and feeling normal by recognizing others facing similar struggles. With the exception of one man, having a supportive interpersonal relationship was associated with improved mood and the end of the escalating cycle of depression. As Participant 9 noted, “I just had her and got married. I don’t know if you know who he [therapist] is in (nearby city). That guy . . . he sat down and talked to me. And you know, I told him everything that I could think of what was going on, and he knew.”

**Short-Term Remedies**

Participants reported various attempts to address their depressive symptoms. During the initial stages of their depression, all participants sought and used short-term remedies that provided a reprieve from their symptoms without regard for the long-term consequences of the strategy. Additionally, all participants described attempts at addressing their negative feelings in ways that concealed their symptoms from others. These short-term remedies included substance abuse, infidelity, avoidance, and focusing excessively on work. The short-term remedies these participants described often resulted in only limited relief and were repeatedly related to aggravating factors. For example, Participant 1 noted, “I’d wake up having a hard time stomaching the day and then just to make everything kinda go away, I go drink excessive amounts, at least 10 drinks at a sitting.” Similarly, Participant 7 described his short-term remedies as, “I started playing a lot more video games at home and . . . never actually do anything productive or social or productive around the house.”

**Long-Term Remedies**

While participants experienced extended periods of emotional turmoil, eventually all reached some resolution to their depression that lacked the negative consequences associated with short-term remedies. Solutions used to successfully cope with depression included psychotropic medications, individual therapy, couple’s therapy, group therapy, and religious counseling. A key factor to the success of these long-term solutions was the ability of the participants to increase the level of responsibility they took for resolving their issues. Participants reported that their efforts resulted in increased helpfulness, increased knowledge of their disorder, and supportive interpersonal relationships. As Participant 1 described:

And for about the first six months I was really giving it a half-hearted effort. I thought ‘I’ll show up and see what this therapist has to say and take the drug they gave me and things should get better. I just got so sick of the way things were going [and I] realized that there was no way out of this unless I was going to take an active role.

Participant 11 similarly noted, “Once I went to the family physician and the psychotherapist then I took more responsibility.”

**Trial and Error**

Men tended to go through a process of trying many different short-term remedies for coping with their depression until a remedy was found that was consistently successful. This process tended to be prolonged by repeatedly relying on temporary remedies and a desire to hide internal conflicts by handling issues alone. Strategies that tended to pull these men out of their depression were having someone influence them to address their issues differently or to seek professional help. These relationships were most often spousal or partner relationships, with one participant identifying a parental relationship and two others identifying professional relationships as being key in identifying and seeking help for their depression. As Participant 8 described:

She (mother) made a comment, ‘you’re not happy about anything,’ and I’ll always remember that. I thought oh my God, you know, what I am doing to make her see that and I felt bad about myself because I had these feelings and they were true and she said that.
Similarly, Participant 11 noted “I was drowning in my own tears. This little woman on my staff, my son’s age, kinda came to my rescue.”

**Effects of Masculinity**

In response to a query about the role masculinity played in their experience with depression, participants identified only imposed restrictions. Their responses included a sense that depression was not a socially accepted issue for men, that it is inappropriate for men to seek help, that support for men with depression was lacking, and that men who are depressed are often perceived as weak. The most frequently endorsed ways masculinity was seen as affecting men’s experiences with depression were related to social pressure to hide their negative emotions. Participant 6 described this dynamic:

> Well, you don’t like to admit you’re a depressed person. I think that’s very true. You like to think you’re this source of strength and you find out sometimes you aren’t. In my family in particular, there’s . . . a negative view of someone with depression and so you didn’t really let a lot of people know about it.

Participant 14 described a similar sentiment when he noted, “I was brought up not to show my emotions, and in a man’s life you always see on TV where the guys never show their emotions . . . They’re bullet proof . . . The big thing is we don’t show weakness.”

**Recognizing Depression in Men**

The way participants would recognize depression in other men were grounded in the aggravating factors they identified during their experiences with depression. These included both typical (e.g., isolation or a lack of interest in pleasurable activities) and atypical (e.g., anger or overworking) symptoms of a major depressive episode. Participant 6 said that he would notice, “Substance abuse, definitely. Being quieter than usual. I can only say it really for myself and other people that I’ve known. Just kind of avoiding things, denying things, being more agitated and aggressive for no apparent reason.” Participant 13 would note of another man that “He’s just not funny. When he’s bummed out, he’s withdrawn. He doesn’t talk. He doesn’t want to do activities. Or he’ll be into binge drinking.”

**Suggestions for Men**

Included in their descriptions of the limitations of being a male, these men made suggestions to other men coping with depression. Thirteen participants suggested that men should avoid feeling ashamed of their mood disturbance and be more willing to share their feelings with others who might offer support. Additionally, the participants encouraged other men to be more open to seeking help in addressing their depression. For example, Participant 8 reflected:

> I think they (men) need to be open and seek help. I wish I would have had the help when I was younger, because maybe it wouldn’t have gotten this bad. Not be afraid to get help. I don’t think it shows that you’re weak or anything.

Likewise, Participant 14 said

> Men needed to address the problem. I think the hardest thing is to address the problem or to identify there’s a problem with a man. You have to be willing to fall flat on your face. You have to let go of your ego. You have to say, “It’s ok to cry. It’s ok to let out emotions, to show that you’re equal and not superior.”

**Discussion**

The findings of this investigation provide insight into men’s experiences with depression in several ways. First, over the duration of their depressive episodes, men in this investigation reported both typical and atypical symptoms of depression. Second, this study revealed a cyclical, often escalating pattern of depression that required an external intervention or intrusion, usually by a significant other, for escape. Finally, the men in this study consistently articulated the impact of traditional masculine socialization on their reluctance to talk about or obtain help for their depression. These men felt that their experiences were consistent with how most men would deal with depression and urged men to avoid delay in seeking help for depression.

**Typical and Atypical Symptoms**

While previous research studies have confirmed men’s typical symptoms of depression, this investigation provides support for the idea that men also manifest atypical symptoms of depression that can emerge before or during what would be recognized as a major depressive episode as defined through traditional diagnostic criteria. Examples of atypical symptoms reported by the men in this investigation that are consistent with other reports in the research
literature included heightened levels of irritability (Bjork, Doughtery, Moeller, 1997; Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988; Pan, Neidig, & O’Leary, 1994), alcohol and substance abuse (Hanna & Grant, 1997; Mahalik & Rochlen, 2006; Merikangas & Gelernter, 1990; Miller, Klamen, Hoffmann, & Flaherty, 1996), and changes in frequency and intensity of interpersonal conflicts (Cochran, Liu, Boespflug, Dunston, & Sanchez, 2001; Pollack, 1998).

The men in this study reported gravitating toward these atypical symptoms, noting that they resisted the traditional symptoms as being unmanly or inconsistent with their idea of how men should manage a depressed mood. Irritability, anger problems, and overworking tended to be the preferred strategies for managing a depressed mood. Alcohol and substance abuse issues tended to be viewed as ineffective, short-term strategies to manage depression and were not viewed as symptoms per se by the men in this study. However, most men noted concurrent alcohol and substance abuse with their depression.

The Cycle of Maladaptive Coping

Participants found themselves in a cyclical pattern of maladaptive coping that was fueled by a desire to conceal both their typical and atypical symptoms of depression. This cyclical pattern (see Figure 1) began with an initial trigger (e.g., a change in work or social relationships). This trigger frequently led to the development of typical symptoms of depression. The overall functioning of men was affected, including their ability to resolve work and interpersonal issues. In reaction to these early symptoms, a typical response was to attempt to conceal the existence of a mood disturbance from others. The result was either temporary relief or exacerbation of the internal distress, heightened reexperiencing of the early symptoms, and increased external overflow of the internal distress. Over time, this overflow became more apparent to others in the men’s close interpersonal environment, often leading to feedback and intervention.

All men in our study reported being aware of and needing to address internal distress. But in the early stages of their internal distress, out of a need to feel in control or not be perceived as weak, they reported feeling compelled to address their internal distress by themselves. As they attempted to address the distress independently, short-term, maladaptive coping strategies continued to be used more frequently and resulted in more damaging consequences (e.g., substance dependence, infidelity, withdrawal from support systems, suicidal ideation or gestures). These coping strategies often led participants to experience a brief period of relief followed by a return of symptoms which were greater in intensity than originally experienced. When the maintenance of masculine gender role norms restricted men from exiting the escalating pattern of depression, their attempts at hiding their depression continued. This continuation often led to increases in self-destructive behaviors and maladaptive coping patterns. Similar to the big build theory of Brownhill et al. (2005), this cycle continued to escalate participants’ symptoms, often resulting in high-risk or self-destructive behaviors.

Escaping the Cycle of Maladaptive Coping

Intervention by a close friend or loved one was usually required to free participants from their escalating pattern of maladaptive coping. These participants’ experiences illustrated how symptom escalation reduces men’s ability to hide their depression, allowing outside intervention to occur. This intervention was frequently conducted by someone in a significant interpersonal relationship with the man, often a spouse or partner. These interventions highlighted the role interpersonal relationships played in men when a spouse or partner identified their experience as depression. These relationships were fundamental to men overcoming stigma associated with seeking help (Good, Dell, & Mintz, 1989; Mahalik, Good, & Englar-Carlson, 2003; Vogel, Wade, & Haake, 2006). These findings support the results of Mahalik and Rochlen (2006), who reported that college men would tend to discuss depression with a best friend, a family member, or a spouse or partner. The results from this study suggest that men who eventually yielded to someone significant in their life may have already acknowledged that their current ways of coping were ineffective. After having their emotional disturbance identified and treated as depression, they were able...
to find ways to secure long-term relief from their symptoms.

Masculinity and Depression

Participants also described how masculine role norms limited social acceptance of their depressive experiences, prohibited their expression of depression, and restricted the ways they could seek help. These results were consistent with previous research on masculine gender role socialization and the expectation that men conceal their feelings of depression and avoid seeking help for depression even when the need is apparent (e.g., Good & Wood, 1995; Moller-Leimkuhler, 2002). Moreover, the maladaptive strategies reported by the men in this study were designed to conceal emotions. Paradoxically, these strategies promoted a cyclical pattern of depression that consisted of a brief period of relief followed by a return of symptoms (see Figure 1). Similar to the big build theory of Brownhill et al. (2005), the symptoms returned with greater intensity than originally experienced and frequently resulted in high-risk or self-destructive behaviors.

Men in this study had definite recommendations for other men faced with the challenge of coping with depression. They consistently noted the importance of resisting the forces that constrained them from expressing their depression more directly or from seeking help. These recommendations parallel findings that gender role socialization leads men to engage in efforts to distance themselves from depressed or sad mood by keeping a low profile (e.g., Mahalik & Rochlen, 2006) and to avoid seeking help (e.g., Good & Wood, 1995).

Limitations

There are four major limitations to this study. First, the demographic makeup of the sample was restrictive. The participants sampled were almost exclusively Caucasian and predominantly of middle to upper-middle class. Given that the majority of the participants identified as heterosexual, participants’ experiences with depression were potentially biased by a heterosexual worldview. This limitation is amplified given the role sexual behaviors played in some men’s reports of the utilization of infidelity as a short-term remedy for their depression.

Second, participants’ access to health care resources assisted in their effectively addressing their emotional distress. While these men were able to break from the cyclical pattern of depression described in the model, this model may not be representative of men with barriers to health care and mental health resources. Men with fewer resources may require more interpersonal support to help them move past gender-based and financial limitations to help-seeking.

Third, while this study was designed to elaborate a theory of men’s experiences of depression, the criteria for participation in the study may have influenced the results and, ultimately, the model derived from these results. The men who participated were not screened for inclusion according to a set of predetermined criteria for depression. The research team relied on the participants to select themselves based on their understanding of having been diagnosed and treated for depression. A valid question is whether the men actually had experienced a major depressive episode, or whether they might have been treated for a bipolar disorder or some other disorder with prominent features of depression that did not meet criteria for major depression.

Finally, the 8-month time frame between the interview and the follow-up meeting may have contributed to attrition and resulted in a loss of feedback from those participants who did not participate. While the research team felt it necessary to be thorough in their coding, the lengthy delay may have inserted bias in the follow-up data through self-selection of resilient participants. A shorter period of time between interviews may have increased the number of participants in the follow-up meeting and further enriched this study’s findings.

Research and Clinical Implications

This qualitative study provides new information to inform future research on depression in men. First, future research should elucidate the overlap of men’s depression with substance abuse, isolation, and irritability. Second, research examining the negative effect of normative male alexithymia (Levant, 1998) on depression in men is needed. The presence of normative male alexithymia may be a clinical indicator of the need to use interpersonal or systemic interventions to
increase self-awareness and to aid men in interrupting escalating cycles of depression. Finally, research furthering the inclusion of culturally specific criteria in assessing depression in men may help identify depression in men from substance-related issues, interpersonal difficulties, and antisocial disorders.

The findings of this study can also inform the treatment of depression in men in several ways. First, regardless of men’s presenting concerns, men facing changes in work status or disruption of interpersonal relationships can benefit from assessment for depression. Second, an assessment of depression in men should include evaluation of atypical symptoms associated with men’s efforts to conceal a mood disturbance. These atypical symptoms can include substance abuse, excessively frequent or intensely irritable mood, and changes in sexual behaviors including infidelity. Third, clinicians should consider the utility of feminist approaches to the treatment of depression in men. Psychoeducation on the barriers men face in recognizing and identifying emotional states (i.e., normative male alexithymia) is analogous to educating women on the role societal oppression has played in their ability to cope with mood disturbances. Finally, assessing and using important interpersonal relationships to increase support for men’s struggles with depression can potentially help them to avoid withdrawal and engage in effective efforts at symptoms relief. Employing interpersonal or systemic approaches to treatment of men’s depression can facilitate the use of these supportive relationships and expedite the effects of their positive influence.

References


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