WHAT DO MASCULINITIES HAVE TO DO WITH COLLEGE MEN’S HELP-SEEKING FOR DEPRESSION-RELATED SYMPTOMS?

by

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Abstract

Few authors have specifically analyzed college men’s help-seeking for depression. Those studies that have focused on the relationship between college men’s attitudes towards seeking psychological help and the male gender role are limited in that they neglect to contextualize help-seeking behaviours. Earlier studies have also assumed that all college men adhere to traditional masculine ideals in their help-seeking decision-making. This qualitative study analyzed 21 interviews with college men who self-reported as having either clinical depression or symptoms of depression. In acknowledging the multiplicity of masculinities, this study used social constructionism to explore the way in which college men enact their masculinities in various help-seeking contexts for depression-related symptoms. Four key themes were identified: conforming to social norms, maintaining stoicism and limiting self-disclosure around friends and peers, family validating the need for professional help, and preserving autonomy. This study also examined the interplay between college men’s masculinities and their perception of help-seeking for depression symptoms. The findings demonstrate the college men’s masculine ideals surrounding help-seeking for mental illnesses.
Preface

This research had been approved by the University of British Columbia Behavioural Research Ethics Board (UBC BREB). UBC BREB certificate number: H07-00276
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1 Introduction

A 2002 Statistics Canada survey found that 3.7% of men, versus 5.9% of women, reported having major depression during the previous 12 months (Public Health Agency of Canada, PHAC, 2006). In addition, studies have consistently found a higher rate of depression in women compared with men; in fact, the ratio of female to male depression is two to one (PHAC, 2002). Despite the gender differences in the rates of depression, the overall mortality rates due to suicide are nearly four times higher in men than in women (PHAC, 2006). In 2004, suicide was the second leading cause of death in men aged 20 to 24, following accidents (Statistics Canada, 2007a). As well, in the same age group, men had a suicide rate four times higher than that of women (Statistics Canada, 2007a). While suicide is related to a myriad of complex issues, individuals suffering from major depression have a higher risk of suicide than the general population (PHAC, 2006). The Mood Disorders Society of Canada (2010) claims that 15% of people suffering from depressive illness commit suicide. Since this mortality rate exceeds those of cancer and heart disease, the Mood Disorders Society argues that depression should be treated with the same degree of attention and urgency as these other life-threatening conditions.

Courtenay (2000a) stated that gender differences in health and longevity can be explained by health behaviours. The contradiction between men’s low incidence of depression amid high suicide rates therefore warrants attention to men’s help-seeking behaviours. According to Statistics Canada (2007b), a general practitioner (GP) frequently serves as Canadians’ initial contact with the health care system; furthermore, GPs also represent the major gatekeepers for specialist services. Statistics Canada (2001) reported that men are less likely to consult a physician than are women. According to a
more recent study in 2007, based on data from the 2005 Canadian Community Health Survey (CCHS), women aged 18 to 64, compared with men, had higher odds of reporting a consultation with a GP, of having multiple GP visits, and of consulting a specialist (Statistics Canada, 2007b). The results even allowed for the effects of chronic conditions and self-perceived health (Statistics Canada, 2007b). Men’s help-seeking behaviours have pernicious consequences for their health, especially when it comes to depression. According to the PHAC (2002), under-diagnosis and under-treatment of mental health illness can lead to poor health outcomes. In addition, Cochran and Rabinowitz (2003) suggest that, if left untreated, depression in men can be a potentially fatal condition. Furthermore, effective early treatments of mood disorders can lower the risk of suicide (PHAC, 2002).

In summary, although men reportedly have a lower rate of depression than their female counterparts, men’s rates of suicide are four times greater than those of women. The high rate of suicide among young men is particularly disconcerting.

Even though Canada’s publicly funded health care system provides universal coverage to medically necessary health care, free of financial constraints (Health Canada, 2009), men are still far less likely than women to seek help for medical problems. If medical services are accessible to young men, why do they prefer to take their lives instead of seeking treatments for depression? The discordant relationship between men’s lower reported rates of depression and high suicide rates warrants research to examine young men’s help-seeking behaviours for depression.

Gender, as “the network of social, historical, and psychological processes that collectively form ideologies and norms regarding who and how men and women should
be” (Addis, 2008, p. 154), is a critical determinant of men’s health (Courtenay, 1998).

Gender theories examine how masculinity intersects with social contexts and other identity markers such as ethnicity and sexuality to influence a man’s decision to seek medical help. These will be discussed in detail in Chapter 2 of this thesis.

This thesis describes the interaction between young men’s masculinity and their decision to seek help for depression-related symptoms. In particular, the thesis will address the question: How do young men explain their decision to seeking help for their depression-related symptoms, or lack thereof, in various contexts, and how does that relate to the enactment of their masculinities? In addition, this study looks at the interplay between young men’s perceptions of the legitimacy of their help-seeking for depression and their masculine identities.
2 Literature Review

To explain the role of gender in men’s health responses to depression, various frameworks have been proposed by researchers. These include the sex differences theory, gender socialization theory, and social constructionism. Both sex-role theory and gender socialization theory are explained in the following paragraphs, followed by a description of social constructionism, which serves as the theoretical perspective for this study. Subsequently, research evidence about the relationship between gender and help-seeking behaviours, and between help-seeking behaviours and depression will be discussed. Finally, literature pertaining to college men’s help-seeking behaviours for depression will be reviewed. In particular, close attention is paid to the way in which researchers conceptualize masculinity in these studies.

2.1 Sex role theory

The main tenet of the sex differences theory is that gender is characterized by two “static sex-role container[s] into which both biologically males and females are forced to fit” (Kimmel, 1986, p. 520). Kimmel (1986) remarks, “the sex-role paradigm is based upon the traits associated with the role – a kind of laundry list of behavioral characteristics – rather than their enactments” (p. 521). According to Bem’s Sex Role Inventory (1974), for example, while the male’s sex-role is defined as “independent,” “dominant,” “willing to take risks,” and “ambitious,” the female sex-role traits include “yielding,” “compassionate,” ”understanding,” and “gentle” (Bem, 1974).

From this perspective, male anatomical features signify masculinity or manhood (Edley & Wetherell, 1995). The body is compared to a “natural machine” (Connell, 2005,
Robertson (2007) argues, “men’s poorer health outcomes can be seen as stemming directly from a genetic predisposition and/or a hormonal drive that leads to predominately destructive or damaging behaviours” (p. 28).

### 2.2 Gender-role socialization theory: “boys don’t cry”

The gender-role socialization framework proposes that gender-roles are learned and self-perpetuated through processes of socialization (Branney & White, 2008). Men learn gender-appropriate attitudes and behaviours from cultural values, norms, and beliefs about “what it means to be male” (Addis & Mahalik, 2003, p. 7). Akin to stage actors, men have to learn to perform their parts which have been assigned to them (Edley & Wetherell, 1995). According to Möller-Leimkuhler (2002), the traditional male gender-role is characterized by attributes such as “striving for power and dominance, aggressiveness, courage, independency, efficiency, rationality, competitiveness, success, activity, control, and invulnerability” (p. 5).

According to the gender-role paradigm, “social expectation about a person’s status in society produces conformity to a given role and its related set of functions” (Robertson, 2007, p. 29). In Western European cultures, under the masculine gender-role socialization, boys and men are taught to hold back strong emotions, particularly sad emotions (Cochran & Rabinowitz, 2003); in other words, “boys don’t cry” (Möller-Leimkuhler, 2002, p. 5). They therefore develop a heightened threshold for pain or emotional control (Möller-Leimkuhler, 2002).

Certainly, men vary in the degree of their endorsement of particular masculine ideals, and the subscription of particular masculine beliefs can have negative
consequences for men’s well-being (Addis & Mahalik, 2003). Specifically, when it comes to seeking help for health issues, the cultural norms and values regarding the male gender-role contradict many activities accompanied with such acts, such as reliance on others and admitting the need for help (Addis & Mahalik, 2003).

When particular social roles cannot be fulfilled, difficulties emerge (Robertson, 2007). Robertson (2007) claims that when men cannot live up to their internalized notions of gender-role expectations, the result is “male gender role strain” (Pleck, 1981). Robertson further states that the greater internalization of cultural norms of masculinity roles for a person, the more role strain will be experienced by the individual when the gender norms are not met.

2.3 Limitations of the sex-role theory and gender-role socialization framework

The sex role theory and gender socialization framework provide insights into men’s medical help-seeking behaviours, though both frameworks also have limitations. The sex-role theory, for example, obscures the multiplicity of masculinities that men portray (Connell, 2005). In the context of medical help-seeking, the sex-differences approach fails to address the variability in help-seeking patterns among men (Addis & Mahalik, 2003). Addis and Mahalik emphasize that not all men are the same, and it makes little sense to assume that individual men act similarly across all help-seeking contexts. Robertson (2007) also comments that such a simplistic view cannot account for the health inequalities among men of different ethnic groups, social classes, or geographical locations.

While the gender role socialization theory acknowledges variations in men’s endorsement of particular masculine ideals, the gender-role socialization paradigm fails
to account for the context in which men’s help-seeking occurs (Addis & Mahalik, 2003). Addis and Mahalik explain that under some conditions, men who endorse the masculine concept of self-reliance may ask for help. Moreover, according to Galdas (2009), recent qualitative research illustrates that not all men consider traditional masculine ideologies to be integral to their masculine identity or important in their medical help-seeking experience. Nevertheless, masculinity, in the gender socialization paradigm, is clearly treated as a “stable, internal, trait-like construct” (Addis & Mahalik, 2003, p. 8). In addition, Branney and White (2008) argue that the gender-role socialization theory hinges on the fundamental opposition between men and women. While gender is emphasized in this theory, other major components, such as class and ethnicity, are not considered (Branney & White, 2008). Therefore, the gender-role socialization paradigm fails to adequately explain men’s help-seeking behaviours. Like the sex-role paradigm, it relies on an essentialist way of thinking and fails to separate sex and gender (Robertson, 2007).

In summary, the sex-role theory claims that men’s static role identities or psychological traits are responsible for their adverse health practices and outcomes, while the gender-role socialization theory argues that men’s health behaviours are products of socialization in a particular culture. Since both theoretical perspectives are limited in conceptualizing the variation and complexity of masculinity and men’s help-seeking behaviours, the social constructionist theory, which addresses the shortcomings of these frameworks, is a more applicable theoretical framework for the present study.

2.4 Social constructionism

“Gender is not static; it is something that people construct and reconstruct” (Courtenay, 2000b, p. 7). This means that men do not passively accept a socially
prescribed role nor are they socialized by their cultures (Courtenay, 2000a). They have agency to construct and reconstruct the dominant norms of masculinity (Courtenay, 2000a). More specifically, men learn to adopt various behaviours to enact gender as socially prescribed (Courtenay, 2000b). Gender is therefore an “act” (Butler, 2006, p. 360). Butler (2006) further emphasizes that, “there need not be a ‘doer behind the deed,’ but that the ‘doer’ is variably constructed in and through the deed” (p. 357). Butler’s point is that one becomes whom one is through one’s actions.

Connell (2005) emphasizes that “gender is a social practice that constantly refers to bodies and what bodies do” (p. 71). A way to enact or demonstrate gender is through health-related beliefs and behaviours (Courtenay, 2000a), and people adopt health behaviours to “define and enact representations of gender” (Courtenay, 2000a, p. 1388). In fact, these health behaviours are comparable to “tools for constructing gender” (Courtenay, 2000a, p. 1388).

Furthermore, as Branney and White (2008) assert, “gender is multiple” (p. 259). In particular, Connell (2005) makes it clear that many masculinities exist. The “‘pluralizing’ of masculinity – the recognition of multiple masculinities – has been a central tenet of the social constructionist gender framework” (Galdas, 2009, p. 73).

Masculinity arises in a system of gender relations (Connell, 2005). Connell states that rather than classifying masculinity as an object, such as a natural character type, a behavioural average, or a norm, “‘masculinity’, to the extent the term can be briefly defined at all, is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture” (p. 71).
As it is necessary to recognize the relations among different kinds of masculinity (Connell, 2005), Connell suggests a relational approach to explain the practices and relations that construct the main patterns of masculinity in the current Western order. In his model, Connell (2005) accounts for how gender relations operate within race, class, and sexuality. The relations among masculinities include hegemony, complicity, subordination, and marginalization (Connell, 2005).

Hegemony “refers to the cultural dynamic by which a group claims and sustains a leading position in social life” (Connell, 2005, p. 77); it safeguards the dominant position of men and the subordinate position of women (Connell, 2005). Dominating over femininities and other forms of masculinities, it symbolizes power and authority (Courtenay, 2000a) and is embodied in a White, middle-class, heterosexual man (Emslie, Ridge, Ziebland, & Hunt, 2006). In addition, Connell (2005) emphasizes that hegemonic masculinity is not a fixed character type; “it is, rather, the masculinity that occupies the hegemonic position in a given pattern of gender relations, a position always contestable” (p. 76).

According to Connell (2005), as few men actually meet the normative standards of hegemonic masculinity, the majority of men gain from the overall subordination of women by being complicit in sustaining the “hegemonic project” (p. 79). Thus, they benefit from what Connell (2005) labels “the patriarchal dividend” (p. 79). Connell (2005) calls this complicit masculinity.

Homosexual masculinities occupy a subordinated position to hegemonic masculinity (Connell, 2005). Nevertheless, Connell points out that it is not the only subordinated masculinity, as some heterosexual men and boys also get rejected from “the
circle of legitimacy” (p. 79). Race relations may play an integral part in the dynamics among masculinities (Connell, 2005). For example, a marginalized masculinity is always “relative to the authorization of the hegemonic masculinity of the dominant group” (Connell, 2005, p. 80-81). Connell (2005) uses Black masculinities to illustrate his point.

Robertson (2007) suggests that the aforementioned configurations of gender practice, which are “generated in particular situations in a changing structure of relationships” (Connell, 2005, p. 81), will include practices that affect health status. In addition, depending on whether a man is exhibiting a hegemonic, subordinated, marginalized, or complicit form of masculinity, the health risks associated with these forms differ (Courtenay, 2000a). For instance, to clearly establish themselves as men, men use health beliefs and behaviours to enact dominant and hegemonic masculine ideals (Courtenay, 2000a). Their desire to demonstrate these ideals has been theorized to affect them in problematic ways (Galdas, 2009).

Specifically, men demonstrate characteristics of hegemonic masculinity through denying weakness or vulnerability, emotional control, dismissal of help, the appearance of being strong, and the display of aggression (Courtenay, 2000a). Constructing their gender, men may dismiss their health care needs (Courtenay, 2000a). As Courtenay points out, “when a man brags, ‘I haven’t been to a doctor in years,’ he is simultaneously describing a health practice and situating himself in a masculine arena” (p. 1389). According to Courtenay (2000a), power relationships reside in and are formed in the practice of health behaviour. He further argues that, through the “gendered demonstrations of health and health behaviour” (p. 1388) and patriarchy, “[t]he systematic subordination of women and lower-status men” (p. 1388) is made possible.
Jacques Derrida argues that the “presence contains absence” (Burr, 1995, p. 107). This suggests that the presence of masculinity contains the absence of femininity. In a society where gender is most often depicted as a binary, what is constructed as feminine must be rejected to establish hegemonic masculinity (Courtenay, 2000a). Courtenay (2000a) asserts that the adoption of health-promoting or “socially feminised” (p. 1390) behaviours can undermine a man’s ranking among men. According to Courtenay (2000a), for example, the man may risk being relegated to a subordinated status and being called a “wimp” or a “sissy” (p. 1389).

In performing hegemonic ideals through health behaviours, men reinforce strongly held cultural views about men’s bodies (Courtenay, 2000a). These include men being more powerful and less vulnerable than women, and that, compared with women’s bodies, men’s bodies are structurally more efficient and superior (Courtenay, 2000a). In addition, while femininity consists of asking for help and caring for one’s health, the most powerful men are those who consider health and safety as irrelevant (Courtenay, 2000a). “Foregoing health care is a means of rejecting ‘girl stuff’” (p. 1390). As mentioned earlier, however, more than one kind of masculinity is possible; thus in the context of help-seeking for health issues, not all men align to hegemonic masculinity.

Courtenay (2000a) argues that even though men may endorse similar masculine ideals, these ideals are enacted differently by different men. Influenced by age, ethnicity, social class, and sexuality, different men may exhibit toughness, a masculine ideal among young men, in different ways (Courtenay, 2000a). In addition, potential help-seeking situations serve as the contexts in which various patterns of masculinity are actively constructed (Addis & Mahalik, 2003). The intricate nature of masculinities and the way
in which they interact with men’s help-seeking for health issues in various social contexts are illuminated in the following literature review.

2.5 Research evidence

2.5.1 Gender and help-seeking behaviour

Men’s desire to deny weakness or vulnerability is illustrated in the study by Galdas, Cheater, and Marshall (2007), which examined the role of masculinity in White and South Asian men’s decisions to seek medical help for cardiac chest pain. In the study, most of the White participants expressed their fear of being viewed as weak if they sought medical attention for pain that was perceived to be endurable. In fact, they were concerned that others would see them as “hypochondriacs” (p. 225), which contributed to their decision to delay seeking medical help (Galdas et al., 2007). The majority of the White men in the study felt that, until their chest pain became debilitating, they did not consider their cardiac-related symptoms to be legitimate for seeking medical help (Galdas, et al., 2007).

In an effort to illuminate whether or not sufficient research evidence supports the common stereotypical portrayals of men as being reluctant to seek health care, Galdas (2009) examined a body of literature exploring how culturally dominant forms of masculinity, for instance, hegemonic masculinity, interact with men’s health-related help-seeking practices. Galdas (2009) notes that, in the context of experiencing symptoms of prostate cancer, testicular cancer, and chest pain, the constructions of hegemonic masculinity have been shown to have a harmful effect on men’s decision to seek and access medical help promptly. Nevertheless, while men who enact hegemonic
masculinity may refuse to seek help, as they may consider such behaviour as antithetical to their masculinity, not all men support the hegemonic masculine ideals.

Galdas (2009) observes that the studies implicating hegemonic masculinity as having a detrimental effect on men’s disease management, suffer the same problem of homogeneity that is manifested in studies employing a gender-role socialisation analytical framework. In particular, Galdas (2009) questions whether or not all men adhere to the hegemonic version of masculinity; he also explores how other masculinities intersect with men’s help-seeking decision-making. Moreover, Galdas (2009) argues that though Connell (2005) emphasizes the different representations of gender practice, masculinity is still treated as a singular construct by men’s health researchers. In fact, Galdas, Cheater, and Marshall (2005) explain that many studies concluding that “masculinity” influences men’s help-seeking behaviour are based on homogenous samples, who are mostly White, middle-class men. Variations among men, such as in ethnicity and socioeconomic status, have received little attention in the research literature (Galdas et al., 2005). As an illustration, “observing a group of Caucasian men displaying ‘traditional’ masculine behaviours of being tough and self-reliant, translating into a failure to utilize health services, does not adequately explicate the influence of masculine beliefs among men per se” (Galdas et al., 2005, p. 621). Galdas et al. further emphasize that the dominant form of masculinity discussed in the literature can only be understood as a “‘western’ perspective” (p. 621).

As Galdas (2009) asserts, “ethnicity, sexuality, age or occupational role may be a dominant factor in men’s gender representations at certain times and in certain settings, but not in others” (p. 78). An illustration of this concept is evident in the Indian and
Pakistani men’s experiences in Galdas and colleagues’ study (2007), who viewed cardiac-related pain as necessitating medical help. Masculine attributes, from their perception, comprised taking care of one’s health and living for one’s family (Galdas, et al., 2007). Robertson (2003) claims that drawing on particular aspects of identity enables men to explain their engagement with health services. For instance, by forming alliances with feminine ideals, the gay men in Robertson’s (2003) study were able to distance themselves from “straight” men, which explained certain positive health practices. Along the same vein, the disabled men in the study drew on their specific impairment to legitimize their engagement in health behaviour (Robertson, 2003).

Clearly, the enactment of alternative forms of masculinity enabled the men in the above studies to engage in positive health behaviours. Moreover, depending on the context, men may even use hegemonic masculinity to legitimize their medical consultation. O’Brien, Hunt, and Hart’s (2005) study illuminates the contextual nature of men’s medical help-seeking behaviours. In their study on how men of different ages, life stages, and social backgrounds consider seeking help for symptoms of ill-health in relation to masculinity, though the men had a widespread reluctance to consult their doctor for what they perceived to be minor complaints (to avoid posing challenges to their masculinity), a subset of men considered medical consultation to “preserve, rather than threaten masculinity” (O’Brien et al., 2005, p. 514).

For example, the fire fighters in their study asserted that ignoring pain was an ”old school” (p. 513) representation of masculinity. One fire fighter even mentioned that trivializing symptoms was “naïve” (p. 513). For these men, whose occupational role provided them access to a hyper-masculine identity, consulting for even trivial concerns
or for preventing health problems was a means for them to safeguard their careers (O’Brien, et al., 2005). Men also sought help when their problems affected their sexual health (O’Brien, et al., 2005). According to O’Brien et al. (2005), men would rather risk their masculine status by consulting for sexual ill-health than put their sexual performance in jeopardy.

The fire fighters in O’Brien et al.’s (2005) study were able to critique the constraints of the conventional health practices of masculinity because, according to the authors, they were part of a supportive peer group who cared about health matters and were equally motivated to maintain health and their work identity. Men’s constructions of masculinity are “composite, fluid, and contextually dependent” (Galdas, 2009, p. 63). Their impact on men’s health-related help-seeking practices is illustrated by Noone and Stephen (2008), who studied how older rural men negotiated and constructed their masculine identity within the context of medical help-seeking. In particular, the authors noticed that the men in their study drew on the biomedical discourse as well as the morality discourse, as discussed by Robertson (2003), who suggests that men face a moral dilemma between demonstrating some concerns for their health, as a good citizen ought to, and asserting their male identity by being disinterested with health issues. As stated by Noone and Stephens, while the biomedical discourse provides subject positions for doctors and health care users, “the morality discourse positions subjects as virtuous or immoral citizens” (p. 717). At the intersection of the biomedical and moral discourses, a position exists for virtuous health care users, which signifies a feminine character (Noone & Stephens, 2008). According to Noone and Stephens, since dominant forms of masculinity construct men as stoic and reluctant to visit the doctor, the “seldom-user” (p.
718) of health care represents a masculine subject position. As the moral responsibility of health care use was endorsed by the respondents, the rural men in Noone and Stephen’s study were faced with a dilemma. Noone and Stephens argue that their respondents risked being positioned as immoral members of the society by denying medical help; nonetheless, they risked jeopardizing their masculine identity by seeking help willingly, as they had constructed the “regular-user” (p. 717) position for women.

As a consequence, to solve this dilemma, the men in their study resisted the “seldom-user” (p. 718) health care position, a position that symbolized a masculine ideal (Noone & Stephens, 2008). At the same time, compelled by hegemonic masculinity, they constructed their positive health behaviours as legitimate and in opposition to feminine health behaviours, which they constructed as unwarranted and trivial (Noone & Stephens, 2008).

Occupying the “legitimate-user” (p. 719) position, men could identify themselves as regular users of health care while still preserving their masculine identity (Noone & Stephens, 2008). This study shows that while a subject who embodies the masculine ideal of power and control may display stoicism in opposition to feminine weakness, this ideal may also be realized by being a “legitimate user” (p. 719) of health services (Noone & Stephens, 2008). The authors acknowledge that, in a different context, rather than identifying themselves as regular health care users and experts of health issues, the men in their study might have endorsed men’s reluctance to seek help. Indeed, “the construction of masculine identities is best theorised as a process of negotiation in a situated context rather than through the performance of normative roles” (Noone & Stephens, 2008, p. 722).
Courtenay (2000a) substantiates this, asserting that “because masculinity is continually contested, it must be renegotiated in each context that a man encounters” (p. 1393). Evidently, these studies share a common theme. Whether or not a man seeks medical help when illness strikes may depend on the way he constructs or negotiates his masculinity in particular help-seeking contexts as well as on his perception of the legitimacy of his health problems.

### 2.5.2 Men’s help-seeking behaviour and depression

From a gender-socialization perspective, Warren (1983) explains that men may wish to conceal their depression since “depression is incompatible with the male sex role and therefore threatens their sense of masculinity” (p. 150). Specifically, the connection between depression and femininity may give men the strongest motive to hide their depression from others (Warren, 1983). In addition, Warren suggests that the experience of depression is incongruent with the male sex-role, which emphasizes competence, achievement, and success. Since depression brings with it feelings of powerlessness and diminished control, men may interpret depression as a failure to be a man (Warren, 1983). In fact, Warren states that the association between depression and men’s sense of failure is supported by research, suggesting that men may be intolerant of depression because of the subscription of the male sex-role which demands them to be tough, confident, and self-reliant, and showing feelings of depression, such as helplessness, weakness, and vulnerability, represents unmanliness, according to the tenets of masculinity.

Emslie et al.’s (2006) study on men recovering from depression, nevertheless, shows that men reconstruct their own valued sense of masculine identity in their recovery from depression. In particular, the most common strategy for men to rebuild their valued
sense of masculine identity is to incorporate values associated with hegemonic masculinity in their recovery process (Emslie et al., 2006). For example, a number of men reconstructed their identity around hegemonic masculinity by being “one of the boys” (Emslie et al., 2006, p. 2251). Furthermore, the respondents’ narratives emphasized the importance of re-establishing control; their decision to resist medications as well as accept medications could be justified by their need to regain control over depression (Emslie et al., 2006). Some respondents even reinterpreted their depression experience in a way that was consistent with hegemonic masculinity by conceptualizing it “as an heroic struggle from which they emerged a stronger person” (p. 2255), while some drew on responsibility to their family to help them recover from depression and resist suicidal urges (Emslie et al., 2006).

Not all men strive to align their masculinities with hegemonic masculine ideals in their recovery from depression. Emslie et al. (2006) observed that a minority of men constructed other ways to be masculine based on their “difference” (p. 2253) from hegemonic masculinity. In particular, they emphasized that men who suffered from depression had more intelligence or emotional sensitivities than those who did not (Emslie et al., 2006). Emslie et al. (2006) suggest that in men’s recovery from depression, their reflection on different models of masculinity not only allowed them to resist culturally dominant forms of masculinity “but also point to other ways of being male” (p. 2256).

According to Warren (1983), as a result of the male socialization process, men may hold some negative beliefs about depression. “These beliefs are that depression is a sign of femininity, self-indulgence, failure, and weakness” (Warren, 1983, p. 152). A man
who subscribes to such beliefs would have a strong motive to deny depression and a rational explanation to camouflage his depression (Warren, 1983).

Kilmartin (2005) supports this, arguing that since men are socialized to avoid introspection, many men fail to detect that they have a mental health problem that warrants attention. In his article, which describes a masculine style of depression, the author argues that from an early age, to avoid social punishment from male peers, parents, and even from female peers, boys learn to avoid any behaviour that is culturally defined as feminine. As Kilmartin (2005) maintains, in response to emotional conflict, while women stereotypically “act in” (p. 96) by crying, worrying, or discussing sad feelings, men are encouraged to “remain stoic, banish thoughts about their problem from their consciousness, dissociate themselves from their emotions, or convert vulnerable emotions to anger, and take action in response to their feelings” (p. 96). Kilmartin (2005) also emphasizes that, as it is socially acceptable for men to express anger, they may manifest less socially sanctioned emotions into anger. Substantiating Kilmartin’s explanation, Cochran and Rabinowitz (2003) comment that for many men, masculine gender role socialization can obscure a depressive experience, and “alcohol and drug abuse, interpersonal conflict, and externalizing or acting-out behaviour patterns” (p. 138) are, in fact, manifestations of depression for many men.

To investigate men’s response to their depression experience, Brownhill, Wilhelm, Barley, and Schmied (2005) conducted a focus group study with a non-clinical sample of men and women. In the study, the participants shared their experiences of depression as well as their observations of others’ experiences (Brownhill et al., 2005). This study suggests that, constrained by traditional notions of masculinity, depression in
men can be hidden, ignored, or “acted out” (p. 921). Brownhill et al. (2005) observe that, for some men, emotional distress was first manifested in avoidant, numbing, and escape behaviours. As a result of prolonged periods of suppressing or avoiding negative emotions, as well as internalizing problems, psychological distress or emotional pain accumulated, leading to “a build up” of negative emotions (Brownhill et al., 2005, p. 925). When triggered by a negative external event, the “build up” of negative emotions was released in ways that were recognized and acknowledged as being harmful to self or to others. The participants described that, for some men, their “ultimate escape” was self-harm and suicide (p. 925). Brownhill et al. interpret this as the “externally directed physical release of emotional distress” (p. 926). Indeed, Brownhill et al.’s study highlights “the link between what some men ‘feel’ (experience) and what some men ‘do’ (express) when they are depressed” (p. 928).

Brownhill et al. (2005), Cochran and Rabinowitz (2003), and Kilmartin (2005) agree that, as a result of male gender-role socialization, men adopt an “action-oriented approach” (Kilmartin, 2005, p. 96) to express their depressive symptoms. Nevertheless, from a social constructionist perspective, Branney and White (2008) argue that, based on research on depression and hegemonic masculinities, “it might be suggested that the destructive behaviours such as violence in intimate relationships, substance misuse and suicide are ways of ‘doing’ depression that enact particular masculinities” (p. 260). What Branney and White (2008) are saying is that “depression in men is not masked” (p. 260). Men enact masculinities by “doing” (p. 206) depression through “abusive, aggressive and violent practices” (p. 260).
According to Möller-Leimkuhler (2002), in Western societies and cultures, the male gender-role implies not perceiving or disclosing anxiety, problems, and burdens in the face of danger and threats. Even if help is warranted and could be available, the masculine stereotype does not tolerate help-seeking (Möller-Leimkuhler, 2002). Furthermore, help-seeking signifies “loss of status, loss of control and autonomy, incompetence, dependence, and damage of identity” (p. 6). Therefore, men with depressive symptoms may find it challenging to seek help, since help-seeking threatens their sense of masculinity.

Men’s non-disclosure of their struggles or vulnerabilities is evident in Heifner’s (1997) study on men’s experience of depression, in which she conducted semi-structured, in-depth interviews with 14 men who had been diagnosed and treated for major depression. In the study, all men mentioned their lack of connectedness with others, which, according to Heifner (1997), is a feature of traditional masculine socialization. They noted that they could not talk with anyone about their fears and vulnerabilities; furthermore, the men believed that “needing others, depending on others, and expressing truthfully to others, especially other men, was an indication of weakness” (Heifner, 1997, p. 12). The majority of the men in Heifner’s (1997) study perceived their experience of depression as “a sign of personal weakness” (p. 14). Unfortunately, for many men, feeling no relief from the depression and experiencing increased difficulty in hiding their struggles, suicide was a viable option rather than having others see them as being weak (Heifner, 1997). Heifner also notes that almost all of the men considered suicide as a way to regain control of their “out-of-control situation” (p. 15). This illuminates the extent to
which help-seeking challenges men’s masculine identity and how men’s emotional distance from others is detrimental for their health.

O’Brien, Hart, and Hunt’s (2007) study also discusses men’s perceptions about self-disclosure for emotional issues. The authors explore whether or not depression poses different challenges to masculinity, when compared to those posed by other gender-specific or stereotypically male diseases, such as prostate cancer and coronary heart disease. O’Brien et al. (2007) observed that while all participants suffering from depression had gone through a significant life crisis that triggered their illness, any discussion of such occurrences was “notabl(y) absen(t)” (p. 190). The participants provided few details about their experience of depressive episodes (O’Brien et al., 2007). Nevertheless, when talking about other physical illnesses, the men felt less restrained about providing details. The authors explain that these “silences” (p. 190) around and about depression could be understood better in the context of the practice of masculinity.

Conforming to the “conventional practice of masculinity” (p. 190), the men believed that remaining silent and concealing their experience of mental illness was in line with what was expected of them as men (O’Brien et al., 2007). Some confessed that “powerful” (p. 191) rules governed the types of subjects that were appropriate for men to discuss while others spoke about how exhibiting signs of mental illness and breaking the silence about depression could result in negative consequences (O’Brien et al., 2007).

Unfortunately, like the views of many men in Heifner’s (1997) study, the participants in O’Brien et al.’s study felt “it [was] ‘braver’ to conceal problems and ‘take them to the grave’ rather than challenge one’s masculinity by revealing emotion” (p. 193). The absence of discussion about help-seeking or the disclosure of depressive illness
in O’Brien, et al.’s focus groups illuminates how the men were committed to protect their masculine identity.

In Robertson’s (2007) book, the author examines masculine identities and conceptions of health among 20 men who represented a diverse range of masculinities (the same cohort of lay men were also described in Robertson’s (2003) article mentioned earlier). Robertson (2007) highlights that the men in his study experienced uncertainty in identifying whether “minor mental health” (p. 114) problems, such as depression and anxiety, represented an illness requiring health professional intervention. In particular, all of the men in the study believed that having “an identifiable illness, [or] particular injury” (p. 138) offers a valid reason for engaging with health services. As Robertson (2007) states, these men constructed their mental health issues as “personal, family, or social issues rather than health issues” (p. 116). Robertson further elaborates that for many men, seeking professional help for such concerns appeared to represent “an impersonal approach to personal circumstances” (p. 116).

Although accessing health services for coping with daily life difficulties presented a stigma for the men in Robertson’s (2007) study, the author reveals that some men solicited support from their friends to help them manage their minor mental health issues through confiding. This, according to Robertson (2007), is in contrast to the findings of O’Brien et al. (2005), where young men perceived that self-disclosure about emotional concerns was inappropriate.

For example, one participant described that “just being with [his] mates” helped him to take his mind off and “and get on with it” (Robertson, 2007, p. 116). In addition, Robertson notes that, for some men, their use of action-oriented narratives such as
“getting through” or “getting over” their minor mental health problems appeared to be significant in “proving” their hegemonic male identity. Robertson’s study shows that when men confide in their “mates” about minor mental health problems, instead of using verbal communication, they prefer an action-oriented approach. Consequently, Robertson comments that the linkage between action and emotion for men may mean that men deal with their mental health concerns by “doing” (p. 119) as opposed to “talking” (119).

2.5.3 Help-seeking behaviour, depression, and college men

A number of studies mentioned in Courtenay’s (1998) overview of college men’s health reveal that college men who endorse traditional beliefs about manhood experience greater levels of depression and are more susceptible to psychological stress, compared with their less traditionally-minded peers. Moreover, two studies in his review article found that college men’s health risks are magnified as they tend to avoid seeking help from others and under-use campus health services. Courtenay (1998) maintains that by concealing pain and illness, men further increase their health risks, the most extreme outcome of which is suicide. In addition, studies have also identified that, compared with college women, college men are less likely to confide in close friends, express vulnerability, or discuss their problems with others. Their concealment therefore prevents others from realizing that they are in pain (Courtenay, 1998). Furthermore, Courtenay describes the findings in two studies of depressed college students, showing that men are more likely than women to depend on themselves to deal with their depression. Consequently, their responses to depression generate the widespread belief that “college men do not get depressed” (p. 282). Since the reviews of college studies have consistently found no significant gender differences in diagnosable depression among college students, undiagnosed depression in young men may play a role in their high rates of
suicide (Courtenay, 1998). College men’s reluctance to acknowledge their emotional distress, therefore, can have serious consequences for their health, for example, delaying intervention and negatively influencing diagnosis and treatment planning (Courtenay, 2004).

Michael, Huelsman, Gerard, Gilligan, and Gustafson (2006) studied the differential rates of depression and trends in treatment-seeking among college men and women. The students’ current level of depression was assessed with the Depression Scale of the Symptom Checklist 90-Revised (SCL-90-R, Derogatis, 1994, as cited in Michael, et al., 2006). Of 99 men, 17 reached depression scores that were above the “clinical” levels set in the study. Among these men, only five were receiving some form of treatment. Michael et al. found that, though a high percentage of male college students expressed elevated levels of depressive symptoms, a substantial number of them were not being adequately treated. A possible explanation for depression in men is the difficulty in identifying that men’s mood disturbances may be concealed by “co-occurring externalizing symptoms such as substance abuse problems, antisocial behaviour, and interpersonal conflicts” (Michael et al., 2006, p. 66). According to the Canadian Campus Survey (2005), which aimed to determine the individual, social, and environmental determinants of hazardous drinking among Canadian undergraduates in 2004, college men were reported to engage in riskier behaviours, such as cannabis use and harmful drinking, compared with college women. College men were also less likely to report psychological distress than were women. Davies et al. (2000) carried out a focus group study to assess college men’s health needs and the barriers they encountered in adopting healthier lifestyles. The authors discovered that college men’s greatest barrier to visiting
health services was their socialization to disguise vulnerability, and to be independent. According to the authors, although the participants identified and acknowledged that depression was “a common phenomenon for men” due to “grief over the loss of romantic relationships, death of loved ones, low self-esteem, academic and career worries, and seasonal affective disorders” (p. 262), many participants disclosed their resistance to seek help for emotional reasons, unless they were in severe emotional pain. The fear of being judged negatively by peers for seeking help prematurely was also expressed by the men in this study. As Davies et al. maintain, the focus-group members also admitted that the male socialization process, sustained and reinforced by peer pressure, was “a potent inhibitor of help-seeking behaviour” (p. 262). One man stated that seeking counselling indicated “a sign of weakness” (p. 262), and men did not want to appear weak to their peers (Davies et al., 2000). In particular, Davies, et al. (2000) observed that the majority of participants would only use the counselling centre as a last resort.

In Good and Wood’s (1995) study, one of the goals was to examine the relation between male gender-role conflict (MGRC) and college men’s help-seeking attitudes for seeking professional psychological help. The authors’ results highlight that college men’s negative attitudes toward seeking counselling services were related to the restrictive-emotionality component of MGRC, which dictates “what men are not supposed to do” (p. 73), including expressing emotions or being emotionally connected to other men. In fact, the restriction-related MGRC accounted for almost one quarter of the variance in psychological help-seeking attitudes (Good & Wood, 1995). Although the study succeeded in identifying the correlation between male socialization and men’s willingness to use counselling services, Good and Wood (1995) acknowledge that the
study was limited in that the sample comprised mainly male college students of White, middle-class backgrounds.

A more recent quantitative study was conducted by Levant, Wimer, and Williams (2009) on the link between endorsement of traditional masculinity and college men’s health behaviours and attitudes toward seeking psychological help. A non-clinical sample of students was recruited from psychology courses as well as from a university news service. Various facets of traditional masculinity, such as the endorsement of traditional masculinity ideology, conformity to dominant masculine norms, and gender-role conflict, were related to self-reported risky health behaviours, as well as negative attitudes towards psychological help (Levant et al. 2009).

Levant et al. (2009) observed that all three measures of masculinity were negatively correlated with the college men’s attitudes towards seeking psychological help (ATTSPH), so that as the levels of various masculinity variables increased, the willingness to seek psychological help decreased. Levant et al. also note that the combination of these masculinity variables significantly predicted ATTSPH by accounting for 28.6% of the variance. In particular, among the masculinity variables, only the masculinity measure that measures the college men’s conformity to masculine norms made a significant contribution to the variance in the negative direction.

While this finding is consistent with prior research that demonstrated a relationship between conformity to masculine norms and willingness to seek psychological help (Levant et al., 2009), the generalizability of results to men from different ethnicities is limited, since Levant et al. point out that the sample of their study is predominately White and middle class.
Another limitation of the study is that, as previously mentioned, not all men consider the endorsement of traditional masculine ideology to be important to their help-seeking behaviours for health issues: they, in fact, enact multiple masculinities in various help-seeking contexts (Connell, 2005; Courtenay, 2000a; Galdas, 2009; Branney & White, 2008; Addis & Mahalik, 2003). Thus, the masculine measures employed in this study may not be able to provide an accurate measure of college men’s ATTSPH.

2.5.4 Summary of research evidence

The aforementioned studies have used both gender-role socialization and social constructionism as frameworks to analyze men’s attitudes towards seeking help for health concerns. Under the gender-role socialization framework, the traditional male gender role has been shown to have negative consequences on men’s health. Since depression is not compatible with masculinity (Warren, 1983), men may express their depression feelings in ways that are culturally acceptable for men, an example of which is anger (Kilmartin, 2005). Masculine gender socialization can, as a result, obscure symptoms of depression for many men (Cochran & Rabinowitz, 2003; Brownhill et al., 2005). In addition, adhering to the conventional practice of masculinity and gender role expectations, the men in O’Brien et al.’s (2007) study remained reticent towards their depression experience. A lack of connectedness with other men was also described by the men in Heifner’s (1997) study. In regards to college men’s help-seeking for mental health problems, Davies’ (2000) study identified that the male gender-role posed a significant challenge for college men to seek help. Good and Wood (1995) and Levant et al. (2009) support this finding. In short, these studies on college men illustrate the relationship between the endorsement of a traditional male gender role and negative attitudes toward seeking psychological help. Nevertheless, as Galdas (2009) claims, not all men consider
the traditional male gender ideology to be central to their experiences of seeking medical help. While these studies focus on the traditional male gender-role in Western society, they neglect to examine the effect of other patterns of masculinities on college men’s help-seeking behaviours.

In particular, studies have shown that, under the social constructionist paradigm, men construct and reconstruct their masculine identity across various help-seeking contexts, and these constructions of masculinities can be conducive in their medical help-seeking. In addition, masculine identities are negotiable in different contexts (Noone & Stephens, 2008). For example, men use various resources, such as occupational roles (O’Brien et al., 2005), sexuality and disability (Robertson, 2003), ethnic identity (Galdas et al., 2007), and moral responsibility (Noone & Stephens, 2008), to construct their masculine ideals as well as to legitimize their positive health behaviours. In Emslie et al.’s (2006) study, moreover, a minority of men, in their recovery from depression, constructed alternative models of masculinity based on their differences from hegemonic masculinity. It would therefore be interesting to see how college men enact their masculinity in various help-seeking contexts for depression-related symptoms.
3 Methods

3.1 Research questions

As discussed in Chapter 2, a dearth of studies have specifically analysed college men’s help-seeking behaviours for depression. Those focusing on the correlation between traditional male gender-role and college men’s attitudes towards seeking psychological help are limited in that they neglect to contextualize help-seeking behaviours. Furthermore, the studies treat masculinity as a singular trait and assume that all college men adhere to traditional masculine ideals in their help-seeking decision-making. Therefore, this study aimed to understand: How do college men enact their masculinities in various help-seeking contexts for depression-related symptoms? Moreover, among the men who disclose their help-seeking behaviours to others, this study looked at the way they represent their masculinities to others in help-seeking contexts.

To understand the interplay of college men’s masculine ideals and their perception of help-seeking for depression symptoms, the second question asked: How do college men’s lay perspectives about depression relate to their help-seeking strategies and masculine identities?

3.2 Methods

3.2.1 Secondary analysis

Methods refer to “the steps, procedures, and strategies for gathering and analyzing data in a study” (Polit & Beck, 2008, p. 758). Secondary analysis, used in this study, refers to “the use of an existing dataset to find answers to a research question that differs from the question asked in the original or primary study” (Hinds, Vogel, & Clarke-
Steffen, 1997, p. 408). For this study, a secondary analysis was performed on an existing interview dataset collected in a pilot study on college men and depression. Permission to conduct the secondary analysis on the data was approved by the University of British Columbia research ethics board. The primary study’s overarching goal was to explore linkages between masculinity and depression in college-age men, with the specific objective to describe men’s experiences of depression, their patterns of depression treatment, including self-management, as well as their perceptions of mental health care services.

### 3.2.2 Data collection of the primary study

The participants in the primary study were purposively recruited through posting advertisements on a website and in key buildings of a Canadian university campus. In addition, to recruit college men who have been diagnosed with depression, a letter was sent by the principle investigators of the primary study to the university student health services, psychology clinic, and health and counselling services. Semi-structured interviews were conducted using an interview guide developed by the principle investigators of the primary study. Participants were interviewed for 1 to 1.5 hours, and the interviews were digitally recorded, transcribed, and checked for accuracy.

### 3.2.3 Sample

A total of 30 participants were in the primary study. Since college-age men were the subjects for this study, those who were in the range in age from 19 to 25 years were chosen for this study. The sample for this study comprised 21 men. The mean age of participants was 22.3 years, and 95% of them were current university students at the time of the study. 14 of the participants had obtained either a study permit or an immigrant status in Canada, and the rest of the men were Canadian citizens. In terms of sexual
orientation, 18 were straight, 2 were gay, and 1 was “questioning.” While some participants self-identified as having depression, some self-reported that they had been clinically diagnosed with depression. Sample demographics and medical profiles are further described in Appendix A.

**3.2.4 Examination of the primary study’s data collection plan**

Thorne (1998) and Hind and colleagues (1997) suggest that the primary research design must be compatible with the secondary questions or, in other words, the generated data must be amenable to the purpose of the secondary analysis. Judging from the set of interview questions used in the primary study, open-ended and more probing questions were used to solicit detailed responses and ensure the comprehensiveness of the data. A clear linkage was seen between the primary study data and this project’s research questions. Some of the relevant questions from the primary study interview guide included: “What does depression mean to you?” “What is the key to recovery?” “How do you talk to other men about depression?” and “What were the challenges to seeking help?”

**3.2.5 Ethical considerations and critical issues**

Informed consent for the secondary analysis was provided in the original consent for the primary study. Participant interview transcripts were labelled with unique coded identifiers by the primary researchers to maintain participant confidentiality. Pseudonyms are used in the findings to protect the participants’ confidentiality.

According to Thorne (1998), secondary analysis may reinforce or intensify the effect of researcher prejudices that occur when the researcher is the instrument in qualitative research. Moreover, the distance between the secondary analyst and the participants poses a threat to fidelity in the interpretation of findings (Thorne, 1998). In
addition, for a secondary analysis of data, without primary face-to-face encounters, the secondary analysts have no opportunity to gain clarification from the informants to ensure that their perspectives are being accurately captured (Hinds, et al., 1997). Without grounding their perspectives in a real situation, researchers using secondary analysis run the risk of interpreting the findings according to what the researchers seek, as opposed to representing what is actually taking place (Thorne, 1998). To address these issues, strategies to ensure that an accurate representation of the participants’ accounts are described in the following section.

3.2.6 Strategies to ensure quality and integrity in qualitative research

As Guba and Lincoln (1981) state, “For naturalistic inquiry, as for scientific, meeting tests of rigor is a requisite for establishing trust in the outcomes of the inquiry” (p. 103). The authors therefore propose four criteria of rigor to establish trustworthiness in qualitative inquiry: credibility, fittingness, auditability, and confirmability (Guba & Lincoln, 1981). Although the methodology for this study is not naturalistic inquiry, according to Polit and Beck (2008), Guba and Lincoln’s quality criteria are often considered the gold standard for qualitative researchers. Their development of standards for the trustworthiness of qualitative research is analogous to the standards of reliability and validity in quantitative research (Polit & Beck, 2008). Therefore, Guba and Lincoln’s (1981) four major criteria for rigor are used in this study. In the following section, I describe each criterion and discuss strategies used to ensure rigor.

Guba and Lincoln (1981) argue that credibility should be the standard against which the truth value of a qualitative inquiry is evaluated. Sandelowski (1986) emphasizes that credibility is established when a study presents faithful descriptions or interpretations of a human experience to such an extent that it is immediately
recognizable by people who share that experience. In addition, Sandelowski (1986) suggests that researchers can enhance the credibility of research by describing and interpreting their behaviours and experiences as researchers, in relation to the subjects’ behaviours and experiences. In other words, researchers must be aware of how they are influenced by the subjects (Sandelowski, 1986).

In establishing credibility, using a self-reflexivity approach, I was aware that my gender, academic background, personal values, gender-role stereotypes, and any potential bias could affect my interpretation of participant experiences. According to Lincoln and Guba (1985), a reflexive journal acts as a kind of personal diary for which the investigator can reflect on personal values and interests. It also allows the investigator to speculate about growing insights (Lincoln & Guba, 1985). Following Lincoln and Guba’s advice, I documented my personal and emotional responses to the participants’ descriptions in a reflexive journal.

Fittingness is a criterion for evaluating whether or not the study findings can be applied to contexts outside of the study context (Guba & Lincoln, 1981). Furthermore, Sandelowski (1986) argues that the findings of the study must “fit” the data from which they originate, and the findings must reflect typical and atypical elements represented in the data.

Strategies proposed by Sandelowski (1986) were used to manage the threats to the fittingness of the study; for example, typical and atypical elements of participants’ responses regarding their help-seeking behaviours and how these behaviours are related to their concepts of masculinity are reflected in the study findings.
According to Guba and Lincoln (1981), “we are quite convinced that consistency is a reasonable criterion for any inquiry. But we reject the concept of reliability as that term has come to be used in the scientific paradigm” (p. 123). Instead, Guba and Lincoln propose the concept of “auditability” as a more appropriate approach. Guba and Lincoln assert that the documentation of a decision trail, or the audit trail, must be adequately maintained. Such a record allows any reader or researcher to follow and understand the logic of the researcher’s decisions throughout the study (Sandelowski, 1986). In this study, I used analytic documentation to document my thought processes, and particular care was taken “to record the nature of each decision, the data upon which it was based, and the reasoning that entered into it” (Guba & Lincoln, 1981, p. 122). The documentation has been presented to my supervisors and committee member so that they may evaluate the reasonableness of my analytic procedures.

Neutrality refers to “the freedom from bias in the research process and product” (Sandelowski, 1986, p. 33). Guba and Lincoln (1981) believe that confirmability represents the criterion of neutrality in qualitative inquiry. Specifically, Guba and Lincoln indicate that “the issue is not the intrinsic objectivity (in the qualitative sense) of the methods used to generate information or the objectivity of the investigator, but the confirmability of the information once it is obtained” (p. 125- p. 126). According to this view, confirmability lies within the study findings themselves. To achieve confirmability in the study findings, I recorded my inquiries and subjective interpretations of the participants’ narratives in my reflexive journal to point to any potential areas of bias. Thus, the reader can evaluate the extent to which my biases may have influenced the outcomes of the findings.
3.3 Methodology

3.3.1 Interpretive description

According to van Manen (1990), methodology reflects “the philosophic framework, the fundamental assumptions and characteristics of a human science perspective” (p. 27). Furthermore, it includes “the general orientation to life, the view of knowledge, and the sense of what it means to be human which is associated with or implied by a certain research method” (van Manen, 1990, p. 27). In other words, methodology provides the philosophical lens and direction for the study. The methodology for this project is interpretive description (ID), as developed by Thorne, Kirkham, and MacDonald-Emes (1997) and reported by Thorne, Kirkham, and O’Flynn-Magee (2004). A more extensive account of ID is presented by Thorne (2008).

ID departs from the research disciplines that have traditionally governed nursing research and serves as an alternative qualitative methodology for generating nursing knowledge (Thorne, et al., 1997). Thorne and colleagues describe ID as a “generic” (p. 172) study method. According to Caelli, Ray, and Mill (2003), generic qualitative studies exhibit characteristics inherent in qualitative studies, but diverge from others in that they use elements from several methodologies as opposed to adhering to a single known qualitative methodology. In terms of design strategies, the ID approach borrows heavily from some aspects of grounded theory, naturalistic inquiry, ethnography, and phenomenology (Thorne, et al., 2004).

3.3.2 Design framework

With regards to the framework, ID acknowledges the nature of human experiences as contextual and constructed, while accounting for shared realities (Thorne,
et al., 1997). Thorne et al. (2004) explain that “the product of an interpretive description …is a coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon that is being studied and also accounts for the inevitable individual variations within them” (p. 7). Furthermore, the intent of ID is not to generate a “new truth” (p. 7) but to develop what the authors call a “tentative truth claim” (Thorne, et al., 2004, p. 7) that describes what is common in a clinical phenomenon (Thorne, et al., 2004). This method requires the research to go beyond simply collecting and reporting data, to construct an interpretive account of the significance of the themes within the data (Thorne et al., 2004).

The philosophical underpinnings for ID design are derived from the key axioms of naturalistic inquiry, which emphasize the multiple constructions of reality (Lincoln & Guba, 1985). Therefore, Thorne et al. (2004) argue that “reality is complex, contextual, constructed, and ultimately subjective” (p. 5). Naturalistic inquiry also believes that research designs must be emergent (Lincoln & Guba, 1985). Elaborating upon this axiom, Thorne et al. explain that “no a priori theory could possibly encompass the multiple realities that are likely to be encountered; rather, theory must emerge or be grounded in the data” (p. 5).

3.3.3 Justification for the choice of study methodology

ID was the chosen method for this study because it emphasizes the constructed and contextual nature of health and illness experience (Thorne et al., 1997), and because one of the goals in this study is to examine the different ways in which college men enact their masculinities in various help-seeking contexts for depression symptoms. As well, it is well-suited to capture the thematic patterns within participants’ accounts of their perceptions of the legitimacy of help-seeking for depression-related symptoms. As the
products of ID are expected to yield application potential (Thorne et al., 2004), hopefully, the findings of this study can enrich clinicians’ understanding of college men’s enactment of masculinities in contexts of help-seeking for depression as well as how their lay perspectives about depression relate to their help-seeking strategies and their masculine identities.

3.4 Data analysis

3.4.1 Coding and identifying patterns and relationships

According to Thorne (2008), “‘coding’ implies a certain term or signifier being applied or not applied to each data instance” (p. 147). The idea of coding is comparable to colour sorting in an initial load of laundry (Thorne, 2008). Data is partitioned into segments for the purpose of coding, a process of identifying common themes or concepts within the data (Polit & Beck, 2008). In addition, as the objective of ID lies in the realm of themes and ideas (Thorne, 2008), Thorne and colleagues (2004) caution analysts that detailed coding should be avoided as it can divert the mind’s innate capacity to detect patterns among pieces of data. According to Thorne et al., “staying overlong in the microscopic view of the trees has a tendency to blur one’s perspective on the forest” (p. 14). Therefore, for each interview, I zoomed in and out of the details iteratively and engaged in an intellectual inquiry process, which iteratively asked explorative questions such as, “What is happening here?” (Thorne, et al., 2004, p. 14). Thorne et al. explain that by using this process the contextual nature of the data would remain intact. Moreover, I worked closely with each piece of data before moving on to the next, and each interview was read in an iterative manner and reflected on as a whole. As I immersed in the transcripts, besides noting shared thematic similarities across the participant accounts and
data elements, I also took notice of cases that seemed different from the other accounts, as well as representative samples of a concept or element that I had not previously encountered in other cases; these may have been potentially meaningful for my inquiry (Thorne, 2008).

Beyond coding data, to discern the relationships among the pieces and patterns within the data, as advised by Thorne, I “shift[ed] [my] attention sequentially from individual cases to the whole dataset, from groups of similarity within certain cases to various manifestations of difference within other cases” (Thorne, 2008, p. 149).

3.4.2 Comparative analysis

ID draws inspirations from techniques that have been developed for other methodological approaches (Thorne, et al., 1997, 2004; Thorne, 2008). Among the various techniques, for this study, “constant comparative analysis” was used to assist in generating common patterns and themes within the data (Thorne, 2008). This approach was originally developed by Glaser and Strauss (1967) as a grounded theory methodology (Thorne, 2008).

According to Glaser and Strauss (1967), the fundamental rule for the constant comparative method is that “while coding an incident for a category, compare it with the previous incidents in the same and different groups coded in the same category” (p. 106).

Elaborating upon Glaser and Strauss’s (1967) constant comparison method, Thorne (2008) states that the method requires every data piece, such as themes, interviews, or statements, to be compared with all other pieces that may be similar or different from them so that possible relations among the data can be theorized. In this project, the themes derived from the first data were compared vis-à-vis the next, to discern commonalities and differences. The same approach was applied to subsequent
datasets. When I compared the accounts of different participants, I posed analytic questions such as: “Why is this different from that? and how are these 2 related?” (Thorne, 2000, p. 69).

### 3.4.3 Conceptualizing findings

Essentially, in ID, findings reflect several components such as “what the pieces might mean, individually and in relation to one another, (and) what various processes, structures, or schemes might illuminate those relationships…” (Thorne, 2008, p. 161). Thorne describes ID as a “meaning-making activity” (p. 175). The intricate relationships among social contexts, masculinities, and help-seeking behaviours for depression among college men are thus highlighted in the study.

According to Thorne (2008), the analytic processes described by Morse (1994) are precursors to the kind of conceptualization required in the ID method. Morse explains that four cognitive processes are important to all qualitative methods: comprehending, synthesizing, theorizing, and recontextualizing. I have incorporated these processes into my conceptualization of the findings of this study. In the comprehending phase, through iterative reading of the transcripts, I learned about the experiences of the participants. Furthermore, to avoid “the demon of premature closure” (Thorne, 2008, p. 167), and following Thorne’s advice, new notes were taken in each reading as a way to encourage fresh ways of thinking. Comprehension was reached when I was able to identify patterns of the men’s help-seeking and depression experiences within their accounts (Morse, 1994). Synthesizing was completed when I could merge various experiences to describe typical or composite patterns within the participants’ accounts (Morse, 1994). Morse compares this to a sifting process, consisting of “weeding the significant from the insignificant” (p. 30). In addition, at this stage, patterns of variation became more evident
to me. For example, I began having some notions about the variations of help-seeking behaviours within the participants’ accounts. I was also able to detect the various meanings participants ascribed to the usefulness of their help-seeking behaviours.

Theorizing is about asking questions of the data, and about “fitting” (p. 32) alternative explanations to the data. Thorne (2008) describes it as “developing ‘best guesses’ about explanations” (p. 166). For instance, I would constantly question how the participant’s depression-related help-seeking decisions were related to their social context as well as their conceptualization of masculinity. In re-contextualizing, the findings were synthesized into a form that can be applied to other settings or contexts (Thorne, 2008). The findings in the study could possibly apply to other contexts with similar characteristics as the context for the phenomenon under study.

3.5 Conclusion

According to Thorne (2008), “the object of interpretive description will typically be a thematic summary or a conceptual description” (p. 164). The former was chosen for this study, since the goal was not to invent new concepts (Thorne, 2008). The themes that emerged from the analysis were woven into a thematic summary, a description of several themes (Thorne, 2008).
4 Research Findings

Several themes emerged in relation to each question. I will first discuss the themes related to the first question about how college men enact their masculinities in various help-seeking contexts for depression-related symptoms. These themes include: “conforming to social norms,” “maintaining stoicism and limiting self-disclosure around friends and peers,” “family validating the need for professional help,” and “preserving autonomy”. Following this, I will discuss the themes related to the second question about how college men’s lay perspectives about depression relate to their help-seeking strategies and masculine identities. The themes that emerged included: “depression is just a ‘common illness’” and “depression lacks specificity”. All names used in the findings are pseudonyms.

4.1 Conforming to social norms

In some contexts, the participants considered the “social norms” for seeking help for depression as affording them the space and permission to seek help. In contrast, others perceived that socially acceptable behaviour often discouraged them from seeking help. For example, Wan (a 21-year-old second-year student) suggested that his country of origin stigmatized people with mental illnesses: “In [Hong Kong], somehow it labels the patient as people who are weak… They are mentally ill… They are persons within the inferior groups and they might be people in the society who are often neglected.” Being wary of the negative consequences of being labelled with depression in his country of origin, Wan internalized the pain and was steadfastly committed to avoiding professional help and the label of depression that might accompany that action. He admitted:
I have the mindset that if I get involved in the treatment then I will automatically label myself as a person or a patient suffering from depression that can maybe be a vicious cycle to get recovery so I think if I can handle it myself so it’s better not to go to treatment.

Wan avoided being subordinate in aligning to restrained choices around seeking help. Wan also confessed that he did “a lot of thinking” before somewhat reluctantly seeking help from a “social worker” at his high school in Hong Kong. Being secretive about his depression and his decision to seek help, Wan was especially careful that his classmates did not know about his help-seeking and uptake of school health services.

Similarly, Gagan (a 24-year-old engineering student) was aware of the stigma about depression that can emerge in his country of origin, India. Initially, Gagan saw a psychiatrist when he attended university in India; however, seeing his friends “walking around there,” near the consultation room, he decided to stop attending. According to Gagan, in India, to see a psychiatrist indicates that a person is either “crazy” or that “something is wrong with [their] mind.” Gagan said:

The main reason was that the psychiatrist was the main student psychiatrist, so all my friends could easily know that I was going to a psychiatrist. If I was at the psychiatrist more often, I would feel… that people around me would feel that I’m sort of mentally challenged.

Like Wan, Gagan desperately wanted to prevent his friends from finding out about his depression or about his need for help. Nevertheless, when Gagan moved to Canada, his perceptions changed about seeking professional help for depression. In a peer
group that supported help-seeking for mental health problems, Gagan became more receptive to consulting with health care professionals to waylay his emotional distress.

When reflecting on his first encounter with a psychiatrist in India, Gagan commented, “I thought that I could fight [my depression] myself but, I didn’t believe that a psychiatrist could help me. I thought that if I could feel more confident in myself, then I would be able to do it.” After coming to Canada, however, his attitude about seeking professional help changed. When Gagan was asked what actions he planned to take if he became depressed again, he indicated that he was interested in soliciting help from a psychiatrist. Instead of insisting on “fight[ing] it” on his own, he predicted that, “…this time I will take most of his help… I’ll go to a psychiatrist. I believe in medical science more now.” He attributed his new-found belief to his Canada-based friends, many of whom had therapists. When Gagan viewed seeking help for his depression as legitimate, instead of imposing the label of being “mentally-challenged,” he was more at ease to accept professional help without guilt or fear of criticism from others.

Charles (a 24-year-old engineering student) had a similar experience. Originally, he was ashamed about his depression and his need to seek help from a counsellor, but he realized that other people were “in the same boat”. In addition, by knowing that other people sought counselling, he could resolve the “big stigma” about receiving professional help:

I don’t see anything bad about going to see someone, I don’t see anything shameful about seeing… a lot of people… I kind of thought I should be embarrassed to say I was going to see a counsellor to get help…because it seems like a lot of people don’t need help… Why should I need the help and that type of
thing… and then I realized a lot of people have problems that they can’t deal with and they go see a counsellor and I thought, well... why not?

Charles suggested that women, who served as a longstanding conduit between men and health care services, might not be as effective in mobilizing men’s help-seeking efforts as men who embody well known masculine ideals. According to him, help-seeking can be reconstructed or negotiated as a masculine behaviour when it is promoted by men who are “big,” “huge,” and “burly”. Charles remarked:

I think the thing that would help the most is probably if people that are trying to convey the message to guys… are other guys… rather than women… If they were other guys… then I think they wouldn’t feel less masculine. I think sometimes the big deal is that if once you open up with your feelings you’re kind of like a woman… that type of thing… I mean, as odd as it may sound… but the more masculine the guy is… that one trying to tell this other guy… probably would help the most, because you’ve got this big huge burly guy that’s sharing his feelings with you and trying to tell you, ‘Hey, go seek counselling’… I probably think it would help more than having some puny little girl.

Alexandro (a 21-year-old finance student), who was diagnosed with depression by his physician four years before the time of the interview, had no problem accepting pharmacological intervention for his symptoms. According to Alexandro, the people in his social group at his boarding school in Switzerland “were all depressed,” and taking Prozac was actually a social norm for them. He explained that it was “trendy for everyone to take Prozac and that kind of medicine,” and 80% of the people he knew were on
Prozac. Interestingly, his peers tended to steer away from the topic of depression. They would rather disclose, “I’m taking Prozac” than, “I’m depressed.” Perhaps, by saying “I’m taking Prozac,” the men focused on the remedy rather than the ailment. When Alexandro was asked in the interview what advice he might give to a male friend who was depressed, he suggested, “Like, go see a doctor, not a psychiatrist, because it doesn’t sound that good… and start taking medicines… that’s the best way.”

Alexandro had never spoken to anyone about his depression and preferred to deal with it by taking medication. Evidently, his social context offered him a legitimate reason for taking medications, but not for engaging in talk-based therapy for his depressive symptoms. Nonetheless, Alexandro differed from other participants in that he saw Prozac as a prophylactic medicine rather than as a treatment. As discussed later, he claimed that he would go on the medication when in a situation that might provoke his depression, such as moving to a different country. He would then go off the medication once he had “adjusted” himself to the situation.

4.2 Maintaining stoicism and limiting self-disclosure around friends and peers

For many participants, masculinity was tacitly understood as being confident, strong, and independent. Participants felt that revealing depression to others could have negative consequences.

Eshwar (a 25-year-old engineering student), who came to Vancouver to study, hid his depression from friends to avoid being ostracized. He quipped, “Nobody likes a depressed person. I mean ‘misery loves company’, except they don’t… They don’t want to be miserable. So hanging around with somebody who is unhappy is likely to make you a bit unhappy.”
Wanting to conceal his depression from his peers, Akash (a 22-year-old graduate student in engineering) was hesitant about going to counselling:

Maybe something related to like, you know, boys don’t cry. Like if someone goes and gets some help… like goes for counselling some guy… so his friends are going to laugh at him I guess.

He also felt that seeing a counsellor would result in ridicule from his friends:

First, they will just ask me what it’s all about and why did I go there. And if I tell them I was really depressed last week… so they’re going to laugh at me… Like well, what were you depressed about?

Akash further explained, “We’re all guys you know we all hang out together and we’re all having fun all the time.” Possibly, he was revealing that when college men spend time together, there is an expectation that they should enjoy the hedonistic pleasures of each other’s company and not bring out their personal problems.

Patrick (a 24-year-old student majoring in interdisciplinary studies) suggested that people “quickly become outcasts when they become depressed.” Within his peer group, others were expected to deal privately with their depressing matters, rather than bring others down:

You’d rather get them out of the circle because you don’t really want to bring other people down with you in terms of like your social circle or your friends or whatever… If you like talk about it with someone… Like you can talk about it one on one, I guess with some friend, but then, that would just bring them down as well.
Patrick’s comments about revealing his depression to peers also seemed to be influenced by his perception that “being depressed looks like a major liability.” For example, while he wanted to talk about his depression with his best friend, he was worried that he might “bring [his friend] down” or that he might seem to be worse than he was. He stated:

You’re not supposed to open up to other guys about that or like really kind of when you’re supposed to seem like confident and strong and you can accomplish things on your own and stuff like that… That’s what proves your value to other people I think and so like, yeah, by discussing it with other people, just like, I don’t know… lowers your value or makes you look weak …kind of thing… so you just shouldn’t talk about it.

Similarly, some participants perceived that non-disclosure of their depression to their friends and peers was a means for them to present a self-reliant identity. Nehru (a 23-year-old engineering student from India) claimed that he would never say to his friends that he was depressed; instead, he would trivialize it by saying, “Life sucks.” He went on to say, “I’m not the kind of person who can go and say that I need some help… Can you take me out of this? I don’t do that. I’ll just mention the thing.” Towards the end of the interview, Nehru explained that what stopped him from expressing his feelings was “some kind of ego.” He stated that his upbringing in India had taught him to be strong, not weak, which meant being able to “take control of things.” Nehru elaborated: “I know myself that if I’m going around and saying to people that I’m depressed, then I’m not being strong.” He also noticed that men tended to mask their weaknesses. For example, in
the engineering faculty, where many students were men, Nehru knew of other men who would not express negative feelings.

Alfonso (a 23-year-old man who graduated with a degree in international relations) had joined a fraternity at university, and perceived that, within his group of friends, “showing weakness is not a good thing.” He elaborated on what he considered to be weakness: “You really have to show you’re strong, and confident; nothing really fazes you. It’s the whole, like, survival of the fittest, like alpha-male sort of mentality.”

To avoid being a “burden” on others, Alfonso isolated himself from his friends “for the sake of not affecting (them)… like impacting them negatively.” Besides his doctor and a student counsellor at the university clinic, Alfonso told no-one about his depression:

I don’t really feel there’s a need to talk about it, again for reasons of not wanting to bring other people down, as I’m with you right now, really unloading my emotional baggage on another person, and you know really forcing that upon them if they don’t want it.

Alfonso also asserted that he had no desire to transform a “good social event” into “a therapy session.” Later in the interview, he acknowledged that sympathy was attached to depression in society, and revealed that, “sympathy is good in small doses, but I think too much sympathy, and charity, and patronage… when even, you know, paid up… becomes something that’s not empowering for men.” He continued, “I think it can become very emasculating, and really remove a lot of sense of self-worth.” Disagreeing with how society managed depression by using “the easy fix, the quick way out, the corporate, chemical solution,” Alfonso suggested that instead of being given “chemical
solution[s]” or heavy doses of sympathy, a man could be given the opportunity to accept and rise up to a challenge in his management of depression. What he was revealing was that the management of depression symptoms could be reconstructed as an opportunity for men to become empowered and to embody masculine ideals in overcoming the challenge.

Alfonso, in addition, believed that other men had a responsibility to not burden others. Referring to his friends, who were going through similar emotional issues as he was, he stated, “I think … guys in my situation or whatever shouldn’t really burden others with it.”

### 4.3 Family validating the need for professional help

Some men attempted to solicit support from their families for their depression symptoms and treatment, either before seeking professional help or after seeking medical help and commencing treatment. When they perceived a lack of approval from their family members, however, they tended to withdraw from seeking professional help. This theme illustrates how college men rely on their family to validate or restrict their help-seeking for depression-related symptoms.

For instance, Gagan initially sought help from a psychiatrist at his academic institution in his home country. He stopped seeing the professional, however, after just one visit. When asked about his primary reason, Gagan admitted that he discreetly sought his mother’s validation of his depression symptoms. When he perceived his mother’s lack of understanding, he decided to discontinue therapy with the psychiatrist:

I would have continued to go, yeah. I was a little bit lazy, but I would have, in fact, gone. I felt that when I talked to my mom she also didn’t say anything to
support me. I think probably… She also thought, no, maybe he’s just being low these days and he’s not that depressed.

Clearly, Gagan located his mother as his primary health advisor. Although Gagan was aware of his depressed feelings and had even sought professional help for them, he valued his mother’s unstated opinion – that his condition was not severe enough to warrant professional help – more than that of his own as well as his psychiatrist.

With the hope that a psychiatrist could cure him, Eddi acknowledged his desire to solicit professional help for depression. Nevertheless, his efforts were hampered when his father criticized the action, saying: “No, no, no, no, you’re foolish. No, don’t do it. You will be okay.” Suspecting that his father might have misunderstood the severity of his depression symptoms, Eddi explained that, “Maybe, he just thought that I’m … overstating something about my depression …”

Chun also attempted to solicit support from his family to acknowledge his depression symptoms and to justify his medical treatment. When the 21-year-old animal science student, who was born in Taiwan and had lived in Canada for 6 years, finally opened up to his mother about taking antidepressants, his mother became enraged, arguing, “You are healthy. Don’t think you are sick… If you think you are healthy then you’re fine.” She threw away his medications. Afterwards, disclosing that he “kind of believed” his mother, Chun convinced himself that he was fine and even stopped taking medication. He indicated that depression was not accepted in his “Asian culture,” where seeking help from a psychologist or psychiatrist brought shame to one’s family. Although sufficiently courageous to solicit professional help at first, he decided to discontinue
treatment when his family disapproved of him seeking help for the symptoms of depression.

Bao (a 19-year-old nursing student) mentioned a similar experience. His parents were unable to understand that his suicidal thoughts were the result of depression. Bao explained that, “…Culturally, they don’t see depression as an illness… just emotional stress or something like that.” In the interview, he again referred to his parents’ lack of understanding about his illness, “They thought I was just temporarily unhappy. They didn’t see depression as a mental illness.” Although his “school doctor” recommended that he take medication, he was reluctant to accept the treatment option. Hence, he decided to discuss it with his family. His parents disapproved of the medical treatment for his depression. Unable to obtain his parents’ approval for the medications, Bao reported feeling very upset, to the point where he resorted to self-harm. After his non-fatal suicidal episode, Bao began taking medications and his parents no longer opposed their use.

Common to Gagan, Eddi, Chun, and Bao was their dependence on their families for legitimizing their depression symptoms and treatments. Their families were unable to understand or accept the men’s depression, which in turn affected their continuation of the treatment, and their decision to seek professional help for their symptoms. In addition, by discouraging and criticising the men’s decisions to seek help for symptoms of depression, their families were implying that these men did not require professional help for their mental health concerns, as they were seen to be “okay” and “healthy.”

In contrast to the above participants, Thomas (a 23-year-old international relations student), was in a supportive context provided by his family, where he was affirmed and encouraged to seek help for depression. In particular, his family assisted him, by
constructing a masculine ideal that allowed him to feel comfortable about seeking professional help. According to Thomas:

I’m not unique, but I have a different experience because I guess my best friend in high school came out in the middle of grade eleven and so I spent hundreds of hours talking to him about feelings and what not… Also, my family is very much open with how things should feel. I definitely sense it’s not typical for guys.

Thomas was implying that, even though he was aware that being open with feelings was not a common behaviour for men, his upbringing and past experiences allowed him to construct self-disclosure as being normal for him. For example, though Thomas realized that men, “will just deal with it (depression), or think they can deal with it on their own without telling people…” and that talking about depression signifies “a sign of vulnerability,” his disclosure of his depression experience to others, including his general practitioner and counsellor, was part of his masculine identity. He stated:

…my entire experience with health care aspects that I’ve been delivered have been excellent. I can go in and talk to my GP and sort of talk about these sorts of things with him to the same extent I can talk about this with my counsellor.

Thomas’ narrative indicated that his parents were his key influences in his experience of seeking help for his depression symptoms. The ability to engage in therapeutic conversations was constructed by his parents as a strength instead of a weakness for men. This had prepared him for articulating his depression experience in talk-based therapy:

I’m incredibly fortunate I think to have had such a positive all around experience dealing with depression, as odd as that sounds. So is very much anyone I talk to; I
also don’t have a problem with diving right into the deepest conversations… I
don’t know where that necessarily comes from… probably my parents.

Similarly, Charles reported that his mother, who had also experienced depression,
would always tell him that “there’s nothing to be ashamed about having depression
because it runs in the family essentially.” Also, she would compare depression to
“habits,” or behaviours that could be “learn(ed)” from someone who was depressed.
Later, Charles disclosed that he had “no reason” to be ashamed of depression. Thus, his
mother may have influenced how he accepted his depression and his eventual willingness
to accept professional help. Based on the accounts from these two participants, with the
help of their families, some men can break away from the masculine ideal that prevents
them from seeking professional help for depression.

4.4 Preserving autonomy

Gagan said that “men are self-fighters to depression.” Self-management of their
depression was a means for many men to preserve their autonomy. Wan suggested that
professional help was “temporarily useful” and went on to say, “I think it’s up to the
person who faces the challenge and the way that I handle it.” The key to his recovery was
to have “lots of gatherings, or lots of work and a lot of study” to distract him from his
depression. Although Wan was enrolled in a psychology course and was aware of the
treatments for depression (i.e., psychotherapy and psychoanalysis), he was determined to
self-manage.

Khan’s (a 25-year-old engineering student) recovery process was positioned as a
solitary pursuit. Emphasizing his need to “control” his mind and outcomes, he explained:
I’m trying to get free by myself… I don’t believe that a doctor or anyone else can help me… or any medicine can help me out of depression… I believe that it’s not like… some kind of some medicine can help me.

In fact, for Khan, “not going to the doctor or taking medicine” was a helpful way to cope with depression.

Adrian (a 20-year-old natural resource conservation student) proclaimed, “It’s the type of thing where it requires a lot of effort on my behalf as well, which is why, in a lot of ways, I don’t buy medication… you know, take this… problem solved.” At first, Adrian had used antidepressants, but later, he discontinued them, “It’s not so much that they weren’t helping because even if they were sugar pills and it was just placebo… something was going on, but it felt forced.” Adrian also suggested that the medications were “not authentic and not the right way of going about it.” He said:

I’ve confabulated somewhere up there in my own little thoughts it’s all chemicals… They only know how to combine them in so many ways, right? … Nothing that the body can actually produce on its own, can just as perfectly be synthesized in a pill… I just refuse to accept that. Just like ecstasy is fake happiness to the extreme sense… some type of prescription medication that I get from my doctor that has serotonin in it or whatever is just as much bullshit to me.

Critiquing and discrediting the biomedical science treatment of depression, this college man suggested that his recovery from depression hinged on self-management and self-reliance. In addition, implicitly, Adrian situated depression as socially constructed
and not having a biomedical basis. Rather than relying on medications, he believed that his recovery resided within his hegemonic masculine attributes.

As a boy, Adrian had always been told by his father that he could only rely on himself, and consequently, he had always tried to solve his own problems. In describing his plan to get out of depression, he stated, “…taking care of myself like, you know, doing everything that’s healthy… being outside in the sun a lot… eating well… exercising well.”

Here, health promotion activities were taken up by Adrian as remedies for depression. It can be said that maintaining physical health and fitness was a way for him to preserve his autonomy as he recovered from depression.

Similarly, Albert (a 25-year-old geography student), preferred to manage his depression by distracting himself, “going to lots of movies by [him]self,” listening to music, and spending time with others. Reflecting on his preference to deal with his depression on his own, he said, “I like to think that I can take care of it myself, to a point at least.” For many participants, being determined to avoid medication was a key to having a sense of freedom and autonomy. Kit (a 19-year-old student majoring in English), illustrated this theme:

I’ve never been one to enjoy a lifestyle where I’m dependent on an external source just to achieve equilibrium. If it’s going to boost me up to a bit above like alcohol does… okay sure… or bring me a little lower, but like, I’ve always been a person that enjoys that independence and, like, a relationship with Xanax is not something that I was looking forward to.
Alfonso felt that he was self-sufficient and intelligent enough to deal with his depression on his own: he even went “cold turkey” for a few weeks after taking antidepressants for the first time. He believed that he could overcome his depression “naturally” by changing his thought patterns.

I, like, feel like doing things myself, and you know, like being in power of my own abilities. I don’t like making excuses and expecting other people to solve my problems for me. I just thought I’d get off the drugs. I quit it cold turkey about two or three weeks after I started taking it, just basically because I thought it was the placebo effect. And I thought if I build my own mind to, you know, think productively, and not be so negative, and stop making excuses, that I could, you know, overcome it naturally.

Unlike most of the participants, Alfonso sought professional help when he reached “the tipping point,” or as he sensed that his depression was preventing him from pursuing his academic goals. Although he strived to maintain his independence, he sought help from his family doctor when his symptoms became uncontrollable:

It’s only to the point where it becomes, where it interferes with your life, that’s really like clinical depression, that you need to actually go through like… either with both therapy and with medication. So yeah, I mean, like in high school and in university… both… at times, I really felt it was overwhelming, and really limiting myself in terms of what I was doing… what I should do, that I really decided to reach out and kind of get some… what I thought at the time would be short-term help… like a kind of a kick start to get myself on my feet again.
A few participants depended on antidepressants to feel secure and safe from depression. Alexandro explained:

Well, I would say that like it’s something you cannot cure. It will go back and forth like in certain times in life so you just have to realize that it is happening and you have to do something or it will get worse. Start taking medication… I love it.

Treating antidepressants as a prophylactic measure for potential triggers, Alexandro planned to use antidepressants in the future. When asked how he saw depression affecting his future, he felt he would be fine, “as long as they have Welbutrin or Prozac”.

Thomas also accepted medications as part of his treatment. In describing depression without antidepressants, he said:

It feels like clouds just blocking out everything… so, sort of looking back at it… it would sort of be like it was without colour or without music. Just very bland… not so much sad but just bland like there was no stimulus coming in.

Thomas commented that, “When I first went on medication, it felt like someone turned the colour back on.” Coming out of depression was an “exciting” experience and finding himself “back in action,” he was more assertive, competitive, and had fewer inner conflicts. Thomas indicated that, next to “air and water,” his medications were the “most important thing” for him in his life. A common thread that existed among the men, who were either for or against antidepressants, was that they all wanted to be empowered, either by self-management or by soliciting professional help.
4.5 Conclusion

A few important findings are distilled from the themes of the first question. In managing their depression symptoms, through non-disclosure of depression experiences, refusal of depression therapy, as well as self-management, college men enacted the hegemonic masculine ideals of stoicism and self-reliance. Possibly, for college men, these strategies enabled them to reconstruct or restore their masculine identity, which might have been threatened by their depression experience.

Those who decided to seek help for depression symptoms used families and social norms to legitimize their help-seeking. For example, the college men were more responsive to seeking help for their depression-related symptoms when help-seeking aligned with their perceived peer group social norms. A few college men, in addition, relied on their families to validate their symptoms so they could either seek formal help or continue with their treatment. Therefore, in the context of help-seeking for depression, relying on social norms and families to legitimize help-seeking can be seen as strategies for young men to maintain their masculine identity.

4.6 Depression is just a “common illness”

College men’s perspectives about depression appear to relate to their help-seeking strategies and masculine identities. Defining depression as a chemical imbalance or a disease was a way for some participants to legitimize their help-seeking for depression. It provided a framework or tool for the men to better understand their symptoms.

As an illustration, Thomas, who visited his doctor for his depression symptoms after researching depression on the Internet, maintained, “I really much feel that
depression is like any other injury that you have,” implying that depression should not be treated differently than physical injuries.

Prior to seeking help, Bao did not know that he was “clinically depressed” even though he would tell people “I want to die…” He declared, “I didn’t know I was depressed… I knew how I felt but I didn’t know ‘depressed’ was the word for it.” Moreover, he thought “treatment [was] for the crazy” and associated mental disorders with “crazy people”. After seeking help from a counsellor, who offered him a scientific explanation, and who compared depression to diabetes, he decided that treatment would be the best way forward:

When I just started medication… Yeah, I felt people might think I’m crazy because I have mental disorders and on medication. But it gradually changed… My counsellor told me it’s very much like diabetes… Some people are more prone to this disease because of chemicals in the body.

In sum, the “scientific explanation for depression” allowed Bao to rationalize depression as “a common illness”. While medications were an integral part of his treatment, he was also inclined to seek counselling, and commented, “I needed to talk to someone”. What Bao may have also revealed is that he was able to “legitimately” seek help for depression when depression is “normalized” and situated in the medical paradigm.

Charles was also open to receiving help, after realizing that his depression partly stemmed from a physiological cause that he could not “fix” on his own. At first, he was bewildered, and felt that depression was “a little more esoteric” than physical illnesses. Believing that medical help was for physical ailments, he indicated that depression was a
“gray area”. Unable to isolate the exact causes for his “crappy” feelings, Charles was puzzled by the type of health professional he needed to consult:

It’s kind of hard to find help for it, I guess, so to speak… I mean like if I’m having problem with my back I go see a chiropractor… If I have a chest cold, I go see a doctor… If it’s my heart, I go see a cardiologist… If I feel crappy… who do you go see, right? Because it could be any number of things. It’s just a little bit harder to kind of pinpoint as to what the problem is… especially if it’s something that you haven’t dealt with before… If I’m depressed… I don’t really know what my problem is, and I can’t think of an idea of how to fix it myself so it’s a little more frightening… If I can’t fix it myself, then I get a little more worried. Is it something more severe…? Or what else could it be right…? It’s harder to find help for something that you’re not sure of.

Charles began seeing a counsellor, but he considered the therapeutic effect to be short-lived. After the positive effect subsided, Charles started to sink “back down”. Consequently, he understood that “there’s something else” and concluded that a “chemical imbalance in [his] brain” was part of the problem. By attributing his depression symptoms to a physiological cause, that “some people just can’t produce enough serotonin,” Charles justified his decision to ask for medications from a doctor even though he stated he was “totally against medications” and that he disliked doctors.

Similarly, Scott (a 22-year-old engineering student) compared his depression to a “disease,” which prompted him to seek professional help. Initially, he sought help from his general practitioner (GP) and his counsellor, for anxiety and depression, confessing
that in the past he would have aligned depression with weakness. Eventually, he realized that depression was like an eating disorder, an illness that warranted help from a doctor:

> After you’ve been through it and you talk to people who have been through it… you know that it’s almost like you get sick and you can’t really get… you need to get the help and see your doctor and stuff and monitor it.

For these men, their recognition of depression as a medical illness or a “disease” informed their decision to seek medical help. When the participants began to view their depression as having a biomedical basis, they became motivated to seek options for medical treatment.

When James (a 21-year-old visual arts student) was advised by his parents to see a psychologist when they noticed that he had become more withdrawn, he resisted. Eventually, however, after sensing that his condition had not improved, he began noticing that “the external things” he “hated,” such as his parents and school, were not the root of his feelings. He realized that “it was sort of an issue with [himself] more than anything else”:

> Like I just thought it was like I hated my parents, I hated school, like I hated, I mean basically that, that I thought it was just those external things, like if those were gone then I’d be great. And I did feel like when I actually left (home and/or school), like those, those first couple of hours or something, like it was really good, like it… but it kind of just slid back into…[feeling terrible].

As soon as he acknowledged that his negative emotions stemmed from issues within himself, not from external (social) sources, he became more open to seeking help
from a psychologist and a psychiatrist. In addition, he actively made an effort to get better by learning about cognitive behavioural therapy (CBT) on his own.

Although James did not construct his depression according to a biomedical model or a “scientific” explanation to justify his help-seeking, his realization that his emotional problems had intrinsic causes that he could not change motivated him to seek professional help. Constructing depression as a biomedical problem over which they had no control allowed some participants to seek professional help “legitimately” without threatening their masculine identity.

4.7 Depression lacks specificity

Lacking confidence in the efficacy of doctors, counsellors, or psychiatrists in comprehending and managing their depressive symptoms, the participants were more inclined to seek help for ‘other’ problems. For an illness to warrant professional help, some men believed that it had to be a physical manifestation, since physicians have diagnostic tools for detecting physical injuries and/or providing medical treatments.

Khan, who felt that depression was something that could not be detected through medical technology, complained:

It’s not like… you can touch and fix it… but like I cramped my knee so give that to some MRI [magnetic resonance imaging] and if they see some situation something is not right they can fix it… But I feel that to get in the mind I have to control it by myself. It’s not like somebody will come and touch it and feel it physically and they will fix it… It’s not like that.
The intricacies of Khan’s depression could not be assessed, analyzed, or relieved by his physicians. In other words, the doctors could not penetrate the interiority of his depression.

Gagan was also uncertain about the doctors’ helpfulness in managing his depression. Although Gagan had sought help from a psychiatrist when he was in India, he was uncertain about the efficacy of talk therapy. He asserted, “I was not sure if a psychiatrist could help me or not. Maybe he will just do the talking. Otherwise, I can do it on my own.” For an intervention to be considered effective, Gagan seemed to be looking for something that he lacked – the skills to do it himself.

In addition, conceding that he wanted a “quick solution,” Adrian maintained that “all counselling ever seemed to be was like me spilling my guts to someone and like giving them food for thought and never receiving that quick solution that I would like to get out of it.”

These descriptions illuminate how the men were deterred from seeking help for depression since they felt the treatment for depression was not as concrete as that for physical ailments. In contrast to the previous theme, where help-seeking occurred when the men identified their depression as a biochemical ailment, these participants were reluctant to seek professional help because they conceptualized depression as a mental ailment.

As a possible explanation, going to physicians without legitimate physical evidence of an illness could jeopardize their perceived identity as a stoical, independent man, as it would suggest that they were unable to manage their own problems. When Kit was asked about men’s medical help-seeking for depression, he said:
Seeing a doctor would automatically mean that in the minds of most men that you are sick… You are unable to deal with your share of stuff… Like, honestly, guys do not enjoy baring all to some professional because they… Like getting them in there is one thing and then getting them to talk is another huge issue you know.

Clearly, getting men to see their doctors is not the only problem. Once they do, they face a huge barrier to articulate their health problems. Implicitly, Kit was suggesting that a masculine ideal is that men do not possess an extensive emotional vocabulary or an introspective ability.

When Adrian explained his reluctance to seek professional help for depression, he stated, “I presumed myself as a failure… that I couldn’t deal with my own problems… That my problems had escalated to a point where I needed professional help.”

From these descriptions from college men, masculine ideals around help-seeking might be enacted differently for physical and mental illnesses. In the context of help-seeking for depression, masculinity was demonstrated by the men’s ability to manage their problems independently. In addition, while the men perceived that seeking help for mental health problems represented weakness, they considered seeking medical treatment for physical problems or injuries as a legitimate behaviour. Thus, for college men, seeking professional help for physical concerns might be less threatening to their enactment of masculine ideals than it would for mental health problems.

4.8 Conclusion

How college men conceptualize depression has ramifications for how they seek and take-up help for their depression-related symptoms. When depression is compared to a “physical illness” or ascribed to a biological cause, men showed a willingness to seek
professional help. Nevertheless, when depression is considered a disease that lacks specificity, men refrain from help-seeking, are uncertain of health care professionals’ ability to help, and/or have difficulty articulating the specificity of their ailment.

The men’s narratives show how treatments and illnesses are intricately connected. For example, some participants believed that treatments were warranted only when their illness had physical manifestations, as if they needed concrete evidence to “prove” they had a legitimate medical illness. For example, the first theme suggests that once men adopt the biomedical perspective about depression (i.e., believing depression originates from a “chemical imbalance” in their brain), they become open to seek professional help. On the contrary, the second theme shows how men deny the efficacy of professional help, since they feel that depression symptoms are intangible and thus, not “fixable” by the doctors. This is different than attributing depression to a biochemical malfunction, which allowed some men to legitimize seeking help from professionals without appearing to be a failure or “crazy”.

These findings also demonstrate how the college men enacted their masculine ideals differently in the context of help-seeking for mental or physical illness. The participants located help-seeking for physical illness or injuries as legitimate, whereas, it was a less likely action for mental health problems. Also, they felt that seeking help for physical concerns, such as a knee injury, would pose a smaller risk to their masculinity, since only the doctors had the expertise and medical equipment to “fix” them. As for help-seeking for mental health concerns, the men suggested that masculine ideals were enacted by being able to control and solve their mental health problems without external help. To relinquish control and responsibility for their mental health to doctors might
compromise their masculinity. Most likely, it would be more legitimate for men to seek help for mental health problems if depression were conceptualized as a biological, medical illness. This may explain why some participants more readily solicited professional help after they concluded that depression was a “disease” over which they had no control.
5 Discussion

The findings from this study have illuminated the connection between college men’s management of their depression-related symptoms and their practice of hegemonic masculinity. In addition, this study looked at the interplay between young men’s perceptions of the legitimacy of help-seeking for emotional distress and their masculine ideals. In this Chapter, I analyze how each theme fits into the body of evidence on masculinities and depression. Further, I explore and compare the findings with those in the literature.

5.1 Conforming to social norms

This study illustrates the point made by Addis and Mahalik (2003) that “men’s help-seeking can be influenced by common masculinity norms and be highly variable in different contexts” (p. 11). For example, the findings show that unless help-seeking is affirmed as socially-acceptable among peers, college men avoid such behaviour because they want to refrain from being marginalized by and subordinate to others. Indeed, the men carefully conformed to masculine help-seeking norms in their social groups so that their gender identities would not be challenged.

Similarly, O’Brien et al. (2005) noticed that the younger men in their study were compelled to concur with their peers’ views about “what it was to be a man” (p. 514); thus, it was rare for them to critically examine how these views impeded help-seeking unless it coincided with their group’s representation of masculine identity.
In addition, this study adds to the body of literature by showing that men can help each other to reconstruct the masculine norms around help-seeking for mental health problems, and these norms can act as leverage to get men to seek help for depression.

5.2 Maintaining stoicism and limiting self-disclosure with friends and peers

In his book, “Guyland,” Kimmel (2008) suggests that young men rely on their peers to validate their masculinity and to initiate them into manhood. He also maintains that masculinity always needs to be proven. In this study, many men implied that masculine ideals were enacted by not putting the “burden” on others and by proving their worth to others. They limited their disclosure of their emotional distress to their peers, as it was important for them to not be a “liability”. “After all, part of the definition of masculinity is to act as if one knows exactly where one is going” (Kimmel, 2008, p. 42). Moreover, since men are taught to uphold values such as self-reliance (Courtenay, 2000a), college men tend to not rely on the social support that they have (Courtenay, 2004).

The findings of this thesis concur with those of O’Brien et al. (2005), in that, for many participants, a key practice of masculinity was to endure pain and to cope with mental health or emotional problems without complaining. O’Brien et al. (2005) further describe that men perceive they are expected to conform and reproduce the “practice of masculinity” (p. 515). In fact, in another study by O’Brien et al. (2007), the authors explain that many men described “how exhibiting visible signs of emotional distress or articulating how they felt flouted the conventional practice of masculinity” (p. 190). Likewise, the men in Heifner’s (1997) study expressed that they could not reveal to anyone their fears and vulnerabilities.
Based on these findings, perpetuating the “culture of silence” (O’Brien et al., 2007, p. 193), without breaking or challenging it, seemed to be a way for college men to remain a member of what Connell (2005) termed, “the circle of legitimacy” (p. 79). They felt secure from being subjected to a subordinate position, in relation to other men.

5.3 Family validating the need for professional help

The findings of this thesis are in line with those of Robertson (2003; 2007). As Robertson (2003; 2007) detailed, men face a moral obligation to maintain their health. At the same time, however, expressing concerns with health issues is associated with femininity (Robertson, 2003). Robertson (2007) termed this the “‘don’t care/should care’ dichotomy” (p. 39). To safely resolve this dilemma, according to Robertson (2003; 2007), men needed to provide explanations to legitimate their interest in health practices, “[Health] could not be done just for its own sake” (Robertson, 2007, p. 155). Being encouraged to seek professional help by their significant others (i.e., female spouse or family member) was one of the strategies used by men to legitimize their access to health services (Robertson, 2003; 2007).

In the current study, some college men sought their parents’ support and approval for their help-seeking for their depression-related symptoms. These men may have needed their parents to “legitimize” their help-seeking behaviours for their depressive symptoms. Robertson (2003; 2007) maintained that family members may facilitate men’s access to health services. Indeed, the findings suggest that families can help men to break away from the masculine ideals around help-seeking. Nevertheless, this study also found that, for a few college men, their parents criticized the men’s decision to seek help. In
fact, some parents insisted that the men were healthy. This study therefore shows that the family may also inhibit the college men’s help-seeking for depression-related symptoms.

5.4 Preserving autonomy

Findings from the current study suggest that, in managing their depression, the college men negotiated their masculine identity to conform to the hegemonic masculine ideals. For instance, they preserved their autonomy and sense of control either by accepting or resisting treatment for their depression. As Courtenay (2000a) articulated, “masculinity requires compulsive practice, because it can be contested and undermined at any moment” (p. 1393). To preserve their masculine identity, some college men were determined to self-manage their depression with various strategies, such as distraction, focusing on physical well-being, and self-monitoring. Their difficulties in relinquishing their independence justified their decision to resist medication. Nonetheless, some embraced antidepressant medication because it enabled them to function in their lives.

These findings are also in line with those of Emslie et al. (2006), who found that the re-establishment of control was used as a strategy by the participants to reconstruct their identity around hegemonic masculinity in their recovery from depression.

In Emslie et al.’s (2006) study, men valued their independence in managing their depression, and were willing to accept professional help to maintain their sense of autonomy. In Ridge and Ziebland’s (2006) study, the participants “relegated medication, talking therapies, self-development approaches, and professionals to the status of ‘tools’ that could be of assistance in the recovery journey, rather than experts” (p. 1048). The findings in the current study also suggest that the college men who went on medications
were using them as “tools,” allowing them to self-manage as a means to maintain their independence.

5.5 Depression is just a “common illness”

As indicated at the beginning of this chapter, to manage the ‘don’t care/should care’ dichotomy, men need to legitimize their engagement with health services by ways and means including involving female spouses or family members (Robertson 2003; 2007). The men could also justify their decision to seek professional help by making “a clear distinction between health and illness/disease” (Robertson, 2003, p. 112).

Some men in the current study were willing to engage in talk therapy and in pharmacological treatment for their mental distress. Specifically, drawing on what Noone and Stephens (2008) labelled the “‘biomedical’ discourse” (p. 715), the men solved the “dilemma” by conceptualizing their depression as a biological issue. As they attributed their depression symptoms to a “chemical imbalance,” they placed themselves in the “legitimate-user” position, a term coined by Noone and Stephens (2008). According to Noone and Stephens, the subject’s position “provided by the biomedical discourse” (p. 719), describes a person “who willingly uses health care services when they have a genuine condition” (p. 719). By occupying this position, the men are not only able to construct their positive health behaviours as legitimate but are enabled to maintain a masculine identity (Noone & Stephens, 2008).

The current study shows that college men were willing to seek professional help for their depression, and that the biomedical model of depression could provide them with a “negotiated reasoning” (O’Brien et al., 2005, p. 514) for their “departure”
(O’Brien et al., 2005, p. 514) from the “practice of masculinity”. It also allowed them to take the “should care” approach to their mental well-being.

5.6 Depression lacks specificity

This study also revealed the masculine ideals surrounding help-seeking for physical and mental illnesses. Some participants were disinclined to seek medical help for their depression-related symptoms, perceiving that a genuine sickness must be accompanied by physical or tangible manifestations. For some men, seeking professional help for a problem that lacked specificity might have challenged their masculinity. The intangible nature of their depression symptoms had therefore influenced the men’s decision to seek professional help.

Men’s emphasis on the importance of legitimizing their health problems by the evidence of visible manifestations was indicated by O’Brien et al. (2005). In their study, by emphasising their infrequent visits to their doctors, the majority of the younger men stressed “the need to be obviously injured, seriously ill or pressured to attend before they would consider seeking medical attention” (p. 507). Robertson (2007) also stated that all of the men in his study viewed that “having a clearly identifiable illness, or particular injury” (p. 137-138) represented a valid reason for engaging with health services.

Moreover, Tudiver and Talbot (1999), who studied men’s help-seeking behaviours based on the perspectives of family physicians, found that “men would have to have a tangible problem before they sought help (e.g., getting a physical for a special driver’s license or a focused musculoskeletal problem)”. In particular, a family physician commented, “they come because they have an acute something, twisted ankle, sore throat: ‘I want you to fix it today, because I have to go back to work.’ Sometimes they are
very open: ‘I’ve been sick for three days. I don’t like being sick; make me well’.”

Clearly, having a focused problem gave legitimacy to their help-seeking. The focus on physical symptoms of an illness was creating the concern, for those with mental illnesses (O’Brien et al., 2005).

This theme suggests that the college men assumed responsibility in managing their depression-related symptoms. They also needed to enact the masculine ideal, in which they were capable of controlling their internal distress, not only for themselves, but for other men as well.
6 Recommendations

Potential interventions for this population and recommendations for further research are detailed in this chapter. As Robertson (2003) suggests, “if we can take the time to understand how specific aspects of identity impact on men’s health practices we can generate more opportunities for engaging in effective health work with men, identifying the right triggers that can facilitate change” (p.113). This study reveals many potential “triggers” healthcare professionals can be aware of in facilitating college men to “legitimate” their help-seeking. As an illustration, as mentioned in the findings from this study, the sense of control and autonomy are essential to young college men in their depression experience. These concepts can be seen as levers that can motivate men to seek help for their emotional distress. For example, counsellors can help young men realize that, by keeping themselves mentally healthy, they can exert more control over their educational goals and future plans. In other words, clinicians can draw on college men’s identity as ambitious students to facilitate change in their health behaviours. Reliance on health services needs not be seen by young men as a barrier to independence, but rather as a means to satisfying important educational and career goals.

For men to legitimate their engagement with health services, Robertson (2003) emphasized “a need to provide information and support for men to recognize when illnesses or diseases are present” (p. 112). The findings from this study show that health care providers and school educators need to devise creative ways to help men realize that their depression requires mental health intervention.

For instance, a project called “Mental Health and High School,” initiated by the Canadian Mental Health Association (CMHA), provides information to high school
students, their educators, and parents about the mental health problems and illnesses of students, and how they can affect young people’s learning. Online resources are accessible for students at the CMHA website. On the student resource page, mental disorders, such as depression and anxiety, are categorized as “brain illnesses,” and comparisons are made between these “brain illnesses” and physical illnesses that affect other organs of the body, such as the heart, lungs, or liver. Certainly, the term “brain illnesses” has a more specific meaning and therefore may be more easily understood and acceptable than the abstract term, “mental illnesses”.

As illustrated by the findings of this study, college men who sought formal help applied the biomedical model to make sense of their emotional distress. They believed that their depressive symptoms were due to a biochemical phenomenon. Based on this, they were motivated to adopt positive health behaviours. In health care settings, clinicians can explain to men the pathophysiology of depression in simple, succinct, and specific terms. When depression is associated with a tangible problem, men perceive that they have a legitimate reason to seek help from mental health care professionals. Moreover, in academic and community settings, workshops on mental health can be held to give men a chance to learn about depression, and to dispel their misconceptions about treatments for depression. That said, emphasizing the biomedical paradigm to explain the origin of depression may run the risk of appearing to value Western medical knowledge over complementary and alternative medicine. Young men who adhere to alternative healing practices may not benefit from this approach. Clinicians need to keep in mind these considerations when planning mental health programs for this population.
Based on the findings of this study, college men’s desire to conform to the practice of masculinity may inhibit them from reaching out to their social support network. This has implications for how to promote college men to seek help for symptoms of depression from their peers.

College men may feel less reluctant to seek and accept informal help, or to discuss their experiences of depression with their peers, if given opportunities to reciprocate, such as by offering encouragement and suggesting effective coping strategies to other students who are experiencing similar symptoms. In addition, according to Addis and Mahalik (2003), “From a constructionist perspective, requiring reciprocity in helping transactions… can be seen as a way of preserving status both by avoiding indebtedness and by marking oneself as a strong and competent man” (p. 11).

Student online support groups and forums for depression could be integrated into university student health wellness websites, so that college men would be able to mutually support one another. This would not only provide the men with an opportunity to reciprocate, but would also give them a sense of control and autonomy, masculine ideals that are crucial to college men during their help-seeking process.

For example, recognizing that many depressed people, particularly young men, do not seek professional help, a comprehensive self-help website, informed by the social constructionist philosophy, was set up for college students in the UK (Meyer, 2007). With the help of student consultants who represented diverse demographics and depression experiences, Meyer (2007) developed the website: studentdepression.org, which contains nearly 100 web pages of information and self-help resources on how to tackle depression.
One of the site’s main features is the “Real Student Stories,” where students anonymously narrate their experiences and share strategies for managing low moods and depression. The Real Student Stories cover four topics: “How depression has affected me,” “Why me?” “What’s helped,” and “What I’ve learned.” This online student forum provides a non-threatening space for college students to disclose their feelings of vulnerability to others while being given the chance to support their peers by sharing their coping strategies.

In addition to the student stories, the website has an interactive component. At the “Overcoming Depression Blog,” students can update their progress in their lives and share their thoughts and feelings with others. Other site users can then respond to the entries and offer encouragement and helpful advice. Among the students who post their stories online, many are male students from various ethnicities and sexual orientations. In their stories, the men disclosed how they started seeing health professionals, the type of therapy that worked for them, and how their mood and lives were improved after seeking professional help. The men are also free to reveal their suicidal thinking, feelings of isolation, shame, and insecurities.

A similar student-focused website could be set up as a space for Canadian college men with depression to exchange information about their experiences in navigating mental health services in their communities and in seeking help from counsellors and doctors. They could also discuss how their depression has affected their academic and personal lives. College men, who want to remain anonymous or might feel uncomfortable waiting in a counsellor’s office, could use the online space to communicate and learn from their peers. Furthermore, the findings of this study indicate that men can mobilize
other men’s help-seeking efforts. Connecting with others in an online support group can aid in normalizing the help-seeking for depression among male students. In short, an online forum could serve as a starting point for college men to get some support from their peers and reduce their feelings of isolation. Another benefit is, since the findings of this study point out that some men strived to enact the hegemonic masculine ideal of stoicism as they managed their depression symptoms, an online student forum can afford a space for college men to seek help informally or discuss their symptoms while still holding onto their “silence” about their depression.

For this kind of intervention, a pilot study could be established to assess college men’s readiness to use an interactive online forum to discuss their depression experiences. Further research could also be conducted to investigate whether or not an online support group for students with depression-related symptoms would be beneficial in getting college men to engage with professional mental health services. It would also be useful to determine whether or not such online forums might facilitate college men to seek help for early symptoms of depression.

Recently, male-specific student support groups that explore men’s health issues have become increasingly popular in other parts of the world. According to a report published by The Guardian, Manchester University has formed its first Masculinity Exploring Networking and Support (MENS) Society (Davies, 2009). The purposes of the group are to bring recognition to masculinity issues, raise funds and awareness for men’s mental health, raise awareness for sexual health including testicular and prostate cancer, and increase awareness about male rape and domestic violence issues. Before the MENS Society was established, another college men’s growth group was developed at Virginia
Tech University to provide men with a safe and nonjudgmental environment for students to share their concerns and address men’s health issues (Vareldzis & Andronico, 2000). According to Vareldzis and Andronico, the objectives of the men’s growth groups, called, “Man Alive,” are:

1. To create a supportive social structure for male college students who may otherwise be socially isolated;

2. To model healthy expressions of emotions, such as anger, fear, sadness, and joy;

3. To create a safe space for men to discuss sensitive issues, such as relationships with significant others, sexuality, and substance abuse (p. 94).

Three “Man Alive” groups were developed, with topics that covered: ways to deal with stress and depression, how masculinity varies in different cultures, and the prevention and treatment of sexually transmitted infections (Vareldzis & Andronico, 2000).

A men’s group, akin to the MENS society or Man Alive could be created at Canadian universities. Such support networks could provide a safe environment for Canadian college men to discuss topics related to masculinity and men’s mental health. Furthermore, in constructing the discussion of mental health issues as a masculine norm, these support groups could provide college men an opportunity to construct a masculine identity that resists the hegemonic masculine ideals that inhibit men from seeking help. As Oliffe and Phillips (2008) state, “by allowing men to be ‘one of the boys,’ regardless of whether they are ‘boys with depression,’ stigma can be reduced and a renewed sense of identity and purpose are often accomplished” (p. 199).
Qualitative researchers could interview college men who participate in men’s support groups to explore a number of pertinent questions: Does being in a men’s support group change the way they perceive help-seeking for depression? Does participating in a men’s group affect their masculine ideals around help-seeking for emotional health problems? Are college men more willing to disclose their mental distress if they are given an opportunity to reciprocate? Are college men more willing to consult health care professionals if they are advised by other men in their support group to do so?

According to Vareldzis and Andronico (2000), “many college men in their 20s and 30s do not have well-developed incentives for preventative health check-ups, and they are not likely to make use of the formal healthcare system for decades after graduation” (p. 95). University health and counselling centers thus have a responsibility for getting male students engaged in health promotion and wellness activities during their college years (Vareldzis & Andronico, 2000).

In conclusion, this study reveals the linkages between masculinities and college men’s help-seeking for depression. College men’s help-seeking is strongly influenced by dominant ideals of masculinity. Constructing a hegemonic masculine identity in the context of help-seeking for depression, college men concealed their depression from their peers and self-managed their symptoms. Nevertheless, some college men were willing to depart from the dominant model of masculinity and sought help for depression. In particular, different resources and strategies, such as families, social norms around help-seeking, and the need to be empowered, were taken up by men to legitimize their help-seeking. It can be said that these resources and strategies enabled them to negotiate their masculine identity in various help-seeking contexts. Interventions that promote college
men’s help-seeking for emotional distress can be targeted to help college men legitimize their engagement with health care services.

This study also demonstrates the interplay between college men’s perception of the legitimacy of their help-seeking for depression and their masculine identity. The findings illuminate how masculine ideals around help-seeking differ between medical disorders and mental health illnesses. Unless depression was understood as a biological ailment, college men felt that their perceived identity as an independent man would be threatened if they sought help for their depression symptoms. Health professionals can therefore use the biomedical model of depression as a means to help men to legitimize their help-seeking for their depression.
References


*Journal of Affective Disorders, 71,* 1-9.


# Appendix A: Sample Demographics

Table 1

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Immigrant (Y/N)</th>
<th>Sexual Orientation</th>
<th>Languages</th>
<th>Diagnosis (Y/N)</th>
<th>Type of Professional</th>
<th>When (Diagnosed)</th>
<th>Treatment (Y/N), type</th>
<th>Type of Professional (treatment)</th>
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<td>N</td>
<td>straight</td>
<td>English, German</td>
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<td></td>
<td></td>
<td>Y, anti-depressants, counselling</td>
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<td>straight</td>
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<td>3 years ago</td>
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<td>straight</td>
<td>English, French, Portuguese, Spanish, Arabic</td>
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<td>doctor</td>
<td>4 years ago</td>
<td>anti-depressants</td>
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<td>Y, China</td>
<td>Gay</td>
<td>English, Mandarin</td>
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<td>May, 2005</td>
<td>Y, counselling, medications</td>
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<td>winter, 2006</td>
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<td>Y</td>
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<td>Oct, 2006</td>
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<td>Y</td>
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<td>When (Diagnosed)</td>
<td>Treatment (Y/N), type</td>
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<td>2001</td>
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<td>GP</td>
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