MEN’S DEPRESSION, HELP-SEEKING AND HETEROSEXUAL RELATIONSHIPS:
A SECONDARY GENDER ANALYSIS

by

Teri Lynn Albus

B.A., The University of British Columbia, 2002
BSN, The University of Victoria, 2006

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

in

The Faculty of Graduate and Postdoctoral Studies

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

April 2014

© Teri Lynn Albus, 2014
Abstract

Men’s depression is a complex health care issue in Canadian society. Depression has negative impacts on many aspects of men’s lives including work performance, school achievement and relationship success. Adherence to hegemonic masculine ideals including strength and self-reliance lead some men to keep depression hidden amid broader social stigma whereby mental health challenges are often equated with weakness. Heterosexual men who experience depression rely heavily on relationship support from their women partners and often refuse to seek help from health care providers or engage with public health services. In order for men’s depression services to be effective, they must celebrate hegemonic masculine values including leadership and strength while acknowledging the key role women partners play in encouraging depressed men to seek help. Results include how depressed men go to great lengths to keep it hidden, attempt self-management, say that they want help but seldom make efforts to seek it, rely heavily on their women partners for support, make efforts to shield women partners from the most negative aspects of their condition and acknowledge that their women partners are critical to their recovery.
Preface

This research has been approved by the University of British Columbia Behavioural Research Ethics Board (UBC BREB). UBC BREB certificate number: H008-00315.
Table of Contents

Abstract ......................................................................................................................... ii

Preface ............................................................................................................................ iii

Table of Contents ........................................................................................................... iv

Acknowledgements ........................................................................................................ vi

Chapter 1: Background & Problem Statement ............................................................. 1
  1.1 Men’s depression ....................................................................................................... 1
  1.2 Depression and men’s help-seeking ....................................................................... 2
  1.3 Problem statement ................................................................................................... 5
    1.3.1 Research questions ......................................................................................... 5

Chapter 2: Literature Review ......................................................................................... 6
  2.1 Background ............................................................................................................. 6
  2.2 Masculinities, men’s depression and help-seeking ............................................... 7
  2.3 Men’s depression-related health services .............................................................. 15
  2.4 Conclusion ............................................................................................................. 20

Chapter 3: Methods ...................................................................................................... 22
  3.1 Research questions ............................................................................................... 22
  3.2 Methodology ......................................................................................................... 22
    3.2.1 Interpretive description .................................................................................. 22
  3.3 Procedures & data collection from the primary study ......................................... 23
    3.3.1 Recruitment strategies .................................................................................. 23
    3.3.2 Examination of the primary study’s data collection .................................. 24
  3.4 Secondary analysis ............................................................................................... 24
    3.4.1 Study limitations ......................................................................................... 26
  3.5 Sample ................................................................................................................... 26
3.6 Ethical considerations ................................................................. 27
3.7 Data analysis ............................................................................. 28
  3.7.1 Coding for theme and pattern identification ............................. 30
  3.7.2 Comparative analysis ............................................................ 31
  3.7.3 Strategies to ensure rigor in qualitative research ..................... 32
  3.7.4 Conceptualizing findings ....................................................... 33

Chapter 4: Research Findings ........................................................ 34
  4.1 Introduction & common findings ............................................... 34
  4.2 “It’s not okay to ask for help” .................................................. 35
    4.2.1 Hiding depression .............................................................. 35
    4.2.2 Self-managing while resisting help ..................................... 38
    4.2.3 Partner relationships are critical ......................................... 44
    4.2.4 Advice to other men ........................................................ 47
  4.3 “I just need her to be there and to give me hope” ....................... 49
    4.3.1 Partners as supportive caretakers ...................................... 49
    4.3.2 Importance of acceptance and affection ............................. 51
    4.3.3 Protecting and shielding partners ...................................... 53

Chapter 5: Discussion .................................................................... 56
  5.1 Introduction ............................................................................. 56
  5.2 “It’s not okay to ask for help” .................................................. 56
    5.2.1 Hiding depression .............................................................. 56
    5.2.2 Self-managing while resisting help ..................................... 57
    5.2.3 Partner relationships are critical ......................................... 59
    5.2.4 Advice to other men ........................................................ 60
  5.3 “I just need her to be there and to give me hope” ....................... 62
    5.3.1 Partners as supportive caretakers ...................................... 62
    5.3.2 Importance of acceptance and affection ............................. 62
    5.3.3 Protecting and shielding partners ...................................... 62
  5.4 Conclusion ............................................................................ 63

Chapter 6: Recommendations ...................................................... 65

References .................................................................................. 70
Acknowledgements

I would like to express my sincere gratitude to Dr. John Oliffe for his expertise in guiding me through the development and completion of this thesis. I would like to thank my thesis committee members, Dr. Sabrina Wong and Dr. Victoria Bungay, for their time and thoughtful feedback on my writing. It has been my pleasure to be a graduate student in the University of British Columbia School of Nursing, and I would like to specifically acknowledge Dr. Wendy Hall, Dr. Alison Phinney and Dr. Bernie Garrett for their guidance and support. This thesis would not have been possible without Dr. Oliffe generously allowing me to use his qualitative research data to perform this secondary analysis and the original funding from the Canadian Institutes of Health Research (11R92369). I would especially like to thank my family, friends and colleagues for their support and encouragement.
Chapter 1: Background & Problem Statement

1.1 Men’s depression

Men’s depression is a significant and complex issue (Oliffe & Phillips, 2008), characterized by feelings of sadness and/or hopelessness that alter the ability to function in daily life interfering with relationships, job performance and sleep (Watkins, Lee Green, Rivers & Rowell, 2006). Many researchers, including Van de Velde, Bracke and Levecque (2010), have noted gender inequities in depression whereby men’s depression is diagnosed at half the rate of women’s. Women are also reported as twice as likely to seek help for depression (Branney & White, 2008) yet an alarming trend noted by Oliffe and Phillips (2008) is that depressed men are four times more likely than women to experience suicide.

Singleton, Bumpstead, O’Brien, Lee and Meltzer (2001) reported men’s depression prevalence as 10% in a sample of UK men while depression among American men was noted by Kessler and colleagues (2003) to be between 8-13.2%. Andrade et al. (2003) summarized these North American and European statistics citing world-wide census that indicated 8-12% of all men report experiencing depression at some point in their lives. Safford (2008) argued that adherence to masculine norms including strength and stoicism, may be linked to lower reported rates of men’s depression compared to women. If men do not access help for depression, and/or their depression is not formally diagnosed, it seems likely that men’s depression is under-reported (Safford, 2008).

Men’s depression-related help-seeking practices often give way to self-managing symptoms and/or relying on partners for support rather than accessing professional health services (Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012). Yet the ways that gender and more specifically masculinities shape men’s help-seeking and heterosexual (male-
female) relationships in the context of men’s depression are poorly understood. The goal of this thesis was to describe connections between masculinities, men’s depression, help-seeking and heterosexual relationships as a means to better understanding the needs of men who experience depression and the families who support them.

1.2 Depression and men’s help-seeking

Men’s depression is a phenomena plagued by stigma amid being poorly understood by society and health care providers (Chuick et al., 2009). Depressed men have been reported to “disguise their depressive symptoms” (Kilmartin, 2005, p. 97) and use substances to blunt their negative feelings (Mahalik & Rochlen, 2006) while striving to ensure that others perceive them to embody traditional masculine ideals. Hegemonic masculine ideals as noted by Courtenay (2000) include: the desire to appear powerful, virile, invulnerable, strong and unemotional. Many men will also keep their depression “hidden” from others by choosing to keep their feelings private rather than openly discussing them (Brownhill, Wilhelm, Barclay & Schmied, 2005, p. 927).

In their secondary analysis of British men discussing their experiences with depression, Emslie, Ridge, Ziebland and Hunt (2006) highlighted how men’s disclosures about their depression were related to widely held masculine ideals such that some participants described their recovery from depression as an expression of their strength and the power to overcome. They further discussed that depression affected men’s relationships with partners, family, peers and colleagues (Emslie et al., 2006). Depressed men can be especially reluctant to seek professional help or treatment and if they do seek help, they are more likely to describe physical symptoms than to share how they are feeling emotionally (Oliffe & Ogrodniczuk, 2010a). Concealing depression can result in self-isolation and estrangement from potential sources of support including family,
friends and health care providers while leading men toward self-harm and suicide as a by-product of misdirected attempts to quell depressive symptoms (Emslie et al., 2006).

Men are not only less likely to disclose their depression to health care providers, but when they do so they are also likely to minimize the severity of their symptoms in an effort to decrease their feelings of vulnerability (Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012). Men are half as likely to disclose depression to health care providers compared to women (Kessler, Chiu, Demler, & Walters, 2005). Safford (2008) outlined that some men react to depression through the use of externalizing behaviours including acting aggressively toward others and overusing substances including alcohol. Men often focus on externalizing behaviours when they do choose to discuss their depression using terms like feeling “stressed” (Ogrodniczuk & Oliffe, 2010a, p. 932). Ogrodniczuk and Oliffe (2009) discussed how men filter their self-disclosure which may lead to withholding their feelings in relationships with partners, peers and health care providers. Wilhelm (2009) and Oliffe, Ogrodniczuk, Bottorff, Johnson and Hoyak, (2012) reported that men may be more receptive to discussing treatment options in ways that do not transgress their masculine ideals and/or manly virtues. Some men will be more likely to engage help-seeking behaviours for depression if it interferes with their ability to perform tasks of daily living or fulfilling traditional male provider roles (Oliffe, Kelly, Bottorff, Johnson & Wong, 2011).

There is a growing body of research addressing the intersections of masculinities and men’s help-seeking behaviours. Courtenay (2000) for instance, suggested that men deny their mental health challenges to maintain an outward persona of being a dominant male. O’Brien, Hunt and Hart (2005) confirmed this pattern in their study on men’s help-seeking behaviours in suggesting that health care providers must be trained to identify
depression in men who might attempt to deny it upon presentation to portray their complicity with socially acceptable masculine ideals. Researchers and health care providers designing and implementing policies for men’s depression-related health services need to acknowledge some men’s restrained choices around help-seeking and reticence to be seen as admitting weakness by disclosing their depression (Mahalik & Rochlen, 2006). Noone and Stephens (2008) asserted that health care providers and public health program developers should promote the idea that men can more widely assert their masculine power in being knowledgeable about their health and acting as health leaders in their peer groups. Similarly, Mahalik, Burns and Syzdek (2007) suggested that masculine ideals such as competitiveness could be used to promote positive men’s health outcomes by rewarding participation in treatment premised on improving men’s work productivity. Bolstering competitiveness through accessing depression-related health services can play into how men “do” health and encourage more men to seek help (Oliffe, Robertson, Kelly, Roy, & Ogrodniczuk, 2010, p. 988).

Belief in traditional masculine ideals that reward men by building their capacity through enhancement of their knowledge, power and leadership, can also be utilized in mobilizing men’s self-health (Lohan, 2007). Treatment approaches that allow for men to express masculine traits of strength and power to overcome their challenges with depression might be more acceptable to men and might result in more men choosing to seek help (Lohan, 2007).

In their study on heterosexual gender relations and men’s depression, Oliffe et al. (2011) discussed the central role that women play in their partners’ efforts to seek help. Participants’ heterosexual relationships drifted toward more female-dominant arrangements such that women directly instructed their depressed partners to seek help.
and provided support on many levels (Oliffe et al., 2011). Many participants willingly
gave up socially prescribed male roles and allowed their female partners to assume less
traditionally female roles while navigating their challenges with depression (Oliffe et al.,
2011).

1.3 Problem statement

Connections between masculinities and men’s depression warrant investigation as
many men experience depression but avoid seeking help through accessing depression-
related health services (Branney & White, 2008). The goal of this thesis is to describe
connections between masculinities, men’s depression, help-seeking and heterosexual
relationships as a means to better understanding the needs of men who experience
depression and the families who support them. Examining men’s perceptions of the role
their female partners play in their depression-related help-seeking will contribute
understandings about how best to include and advise the partners and families of men
who experience depression, as well as the health care providers who treat them. Findings
derived from this study can also guide the development of depression-related health
services that are both men-centered and family-centered.

1.3.1 Research questions

The specific research questions were:

1. What are the connections between masculinities, men’s depression, help-
seeking and heterosexual relationships?
2. How do men who experience depression perceive their women partners’
efforts to help?
Chapter 2: Literature Review

This literature review focuses on two relevant issues: 1) masculinities, men’s depression and help-seeking and, 2) men’s depression-related health services. Studies are critiqued through brief description, noting common findings and highlighting how this research project will add to the existing knowledge.

2.1 Background

As discussed in chapter one, statistics regarding the prevalence of diagnosed depression in men are generally understood to be roughly half those of women (Branney & White, 2008; Kilmartin, 2005: Ogrodniczuk & Oliffe, 2009: Oliffe & Phillips, 2008: Safford 2008 and Wilhelm 2009). Researchers suggested that mitigating circumstances including being in a committed relationship (Kilmartin, 2005) and being financially secure (Addis, 2008) are positively correlated with lower rates of men’s depression.

In terms of heterosexual relationships, partners and emotional support in the context of men’s depression, several research articles have emerged. Van de Velde et al. (2010) discussed risk factors for the development of depression including relationship discord while Watkins’ et al. (2006) literature review highlighted how relationship status influenced depression in men such that relationship support was positively correlated with better emotional health. African American men were reported to adhere to traditional masculine ideals including the desire to act in effective provider roles which may have contributed to their ineffectual attempts at self-management including substance overuse and withdrawal from social support systems (Watkins et al., 2006). Brownhill et al. (2005) highlighted similar masculine patterns among Caucasian men who also ascribed to traditional masculine ideals in self-managing depressive symptoms.
2.2 Masculinities, men’s depression and help-seeking

This section of the literature review presents research findings on masculinities, men’s depression and help-seeking. Highlights of the studies and papers are briefly outlined followed by a short summation of common findings. Contrasting ideas are presented and knowledge gaps to be addressed by the current research are described.

The desire to attain deeply ingrained ideals of hegemonic masculinity including appearing strong, sexually virile, independent, invulnerable and unemotional has been associated with many depressed men in refusing to admit that they need help and might lead to poor health outcomes (Courtenay, 2000). Hegemonic masculinity, for the purpose of this study was defined by heterosexual men who are typically well-educated, financially secure and Caucasian or white (Courtenay, 2000). Courtenay (2000) also suggested that men are forced to construct their own masculine identities amid feeling societal pressure to measure up to dominant and socially acceptable ideals. In this regard, some men might be more likely to deny that they have depression rather than admit an illness synonymous with weakness. Courtenay further described how masculine ideals constrain treatment choices and render men more likely to attempt to privately self-manage depression rather than outwardly seek help. In an effort to keep their struggle private, some men might rely on relationship support whereby their partners are key to their depression-related help-seeking and management (Courtenay, 2000).

In their secondary analysis of interview data, Emslie et al. (2006) examined the interplay of masculinity and depression in men who self-identified as depressed. Participants placed high value on the importance of maintaining control over their lives, hiding their emotions and not showing weakness related to depression while they espoused membership within the dominant, powerful male group (Emslie et al., 2006). In
contrast, it was also noted that some men should be celebrated as leaders for choosing to seek help when faced with health concerns like depression (Emslie et al., 2006). Relationship support was also found to be helpful in constructing meaningful recoveries from depression, amid participants’ pride in their ability to be “different” from other men in connecting with their emotional health (Emslie et al., 2006).

Mahalik and Rochlen (2006) examined masculinities among male college students asking how they would respond to a depressive episode in their lives. Findings included reliance on female partners for support, using substances to avoid feelings, engaging in exercise and seeking assistance from a health care provider (Mahalik & Rochlen, 2006). Belief in traditional masculine ideals including the desire to appear strong was positively related to the participants who reported reliance on female partner support and avoidance measures such as substance use (Mahalik & Rochlen, 2006). Participants further suggested that relationships with women partners provided a private outlet for men to express their feelings while living with the challenges of depression (Mahalik & Rochlen, 2006).

In a 2008 theory-based article, Addis used a deductive reasoning process in applying theories of masculinity to test associations and make predictions about masculine ideals and health behaviours in an effort to develop a deeper understanding of how men experience and cope with depression. Addis noted that men who align with traditional masculine ideals including strength and stoicism, might be more susceptible to developing depression if they withhold from expressing their true feelings. This might result in increased levels of acting out behaviours such as escalating substance use and engaging in other self-management activities including social withdrawal (Addis, 2008). Addis also noted that men are faced with a double standard; they are socially pressured to
embody what is for many, an unattainable masculine role including being strong, invulnerable and unemotional while they are simultaneously discouraged from expressing any difficulty they might have with doing so.

In a contrasting theme, Addis (2008) further suggested that men who do not subscribe to rigid, traditional ideals of masculinity might have been socialized to believe that it is acceptable to engage their relationship support network in working through their feelings and acknowledging emotional challenges. Traditional, socially acceptable masculine ideals including acting independently and valuing self-reliance might lead men to prefer an approach to help-seeking that is problem-focused and leads toward a step-by-step process for tackling the challenges before them (Branney & White, 2008). These men might engage in treatment for depression while relying on relationships with their partners to assist them in developing positive coping strategies (Addis, 2008).

Addis (2008) stated that some men might refuse to seek help or choose to conceal their depression while engaging negative coping strategies. He argued that men might not express their depression to partners, peers or health care providers because they have been socialized to internalize feelings such as sadness in order to assimilate into acceptable masculine role norms (Addis, 2008). Many men are faced with social pressure to present strong, competent exteriors while hiding their challenges with depression and consequently choose to not seek help (Addis, 2008).

Safford (2008) published a reply to Addis’s (2008) theory-based discussion of gender and men’s depression. Safford (2008) agreed that men who hold traditional masculine ideals might be more likely to engage in “externalizing” behaviours such as acting out their feelings by using substances and/or by expressing anger and aggression. Other examples of externalizing behaviours include engaging in risk taking activities or
self-harming behaviour (Addis, 2008; Branney & White, 2008; Brownhill et al., 2005; Safford, 2008 and Wilhelm, 2009). When depression was left untreated, the tendency was for severity to build and self-management attempts to become externalized and more destructive (Brownhill et al., 2005). This finding has been noted by other researchers and suggests men might be more likely than women to “act out” or externalize their depression (Wilhelm, 2009, p. 102). Depressed men might also be so intent on avoiding their negative feelings that they act out through violence which could ultimately lead to suicide (Brownhill et al., 2005).

There is consensus that women are twice as likely to report and seek help for depression but that actual numbers of men silently coping with depression might be similar (Brownhill et al., 2005; Chuick et al., 2009; Emslie et al., 2006; Safford, 2008 and Van de Velde et al., 2010). Branney and White (2008) suggested that several theories can be used to examine the gap in reported cases of men’s depression. Specifically, Branney and White discussed how components of gender role theory, sex differences and dominant concepts in masculinity including the desire to appear invulnerable might assist in explaining why men choose to conceal or deny the challenges they face in coping with depression. Branney and White also suggested that gender role theory could be used to assist in developing a deeper understanding of the complexities of the experience of men’s depression.

In a 2005 study, Brownhill et al. examined men’s experiences with feeling “down in the dumps”. Men described their maladaptive self-management strategies as including both internalizing and externalizing processes (Brownhill et al., 2005). The findings from this study have subsequently been echoed by other researchers and suggested that men might be likely to internalize and attempt to self-manage depressive symptoms by
withdrawing and hiding feelings (Branney & White, 2008; Brownhill et al., 2005; Chuick et al., 2009; Emslie et al., 2006; Safford, 2008 and Van de Velde et al., 2010).

In a study by Oliffe et al. (2012) examining masculinities, men’s depression and suicide, participants explained how relationship support from women partners helped them quell suicidal thoughts. In essence, by aligning to traditional masculine breadwinner and protector roles, many men countered their suicidal ideations and focused on effectively managing their depression (Oliffe et al., 2012). Suicide, in this regard was synonymous with “weakness” (p. 511) and the men chose to exercise power through connecting with their partners and fulfilling traditional masculine roles including acting as reliable providers (Oliffe et al., 2012).

Chuick et al. (2009) presented results from a study that revealed how depressed men’s substance overuse, increased feelings of aggravation and anger, infidelity and avoidance of their true feelings separated them from the significant relationships in their lives. Efforts to avoid and deny challenges with depression led these participants toward cyclical, ineffectual patterns whereby they reported increasing levels of severity in their depressive symptoms (Chuick et al., 2009). Participants also shared how their ineffectual attempts at self-management negatively impacted their relationships, which was a pattern they were also able to recognize in peers who exhibited similar behaviours (Chuick et al., 2009).

In a study of depressed college men, findings include similar patterns in reports of substance use and refusal to seek help based on beliefs about traditional masculine ideals (Oliffe et al., 2010). Culturally dominant masculine ideals of strength and denial informed some men’s efforts to pass as being well while privately suffering from depression (Oliffe et al., 2010). Similarly, Wilhelm (2009) previously stated that some
men might act to keep depression private and might be more likely to withhold discussing their feelings with health care providers.

Chuick et al. (2009) reported that successful outcomes for depression-related help-seeking efforts among the men in their study were incumbent on their ability to take responsibility for engaging with health care providers in the treatment process while relying on support provided by women partners. The men revealed that the social support of other men experiencing similar circumstances was also critical to their recovery from, and management of depression (Chuick et al., 2009). Chuick et al. also noted that the support of loved ones and peers was crucial in reducing the stigma that surrounds public misunderstandings of depression among men.

Oliffe et al. (2011) examined the perceptions of depressed men and their women partners to reveal key relationship dynamics. The findings highlighted how depressed men’s choices regarding help-seeking were influenced by their women partners in relation to their joint beliefs about masculinity and femininity (Oliffe et al., 2011). The participants who most closely identified with traditional masculine and feminine role identities were resistant to acknowledge the men’s depression, more likely to use substances and less likely to seek help. Themes regarding substance use, avoidance and power relations were also evident and some of the female participants reported they refrained from substance use as a result of witnessing the destructive patterns of their partners’ attempts to “avoid” (p. 781) their depressed feelings (Oliffe et al., 2011). Interestingly, while all of the female participants reported they provided support for their partners, the men reported adherence to the traditional masculine ideal of self-reliance in denying that they were dependent on relationship support (Oliffe et al., 2011). As is evident in other men’s depression studies, some couples also reported difficulties and
disruptions with their sexual intimacy patterns (Oliffe et al., 2011).

Johnson et al. (2012) also examined men’s experiences with help-seeking for depression and shared similar findings regarding the importance of relationship support. Also presented was a contrasting theme; some men’s alignment to traditional masculine ideals prevented them from seeking help, while others highlighted their strength to “take responsible, independent action” (Johnson et al., 2012, p. 351). This finding is concordant with the earlier results of Brownhill et al. (2005). While Johnson et al. (2012) described adaptive help-seeking actions by some men, they also emphasized how participants might choose to withhold the true extent of the seriousness of their depression and life challenges.

Kilmartin (2005) pre-empted the findings of many other researchers including Ogrodniczuk and Oliffe (2009) and Wilhelm (2009) stating that men engage in significantly higher levels of ineffective self-management strategies including substance use in misguided attempts to blunt or avoid depressive symptoms. Typical self-management tactics including distancing from negative feelings associated with depression lead men to engage in behaviours that create a sense of safety through self-isolation (Ogrodniczuk & Oliffe, 2009). Ogrodniczuk and Oliffe (2009) suggested that suffering alone might otherwise be mitigated through therapeutic treatment practices that celebrate the courage required for many men to begin the process of emotional disclosure. Sharing feelings about depression with a health care provider might ultimately act as an empowering force in a man’s life (Ogrodniczuk & Oliffe, 2009).

In summary, recurrent themes around depressed men’s attempts at self-management include: discussing feelings with their partners or engaging in exercise (Mahalik & Rochlen, 2006), using substances, risk-taking or acting out behaviours
over working (Addis, 2008) and suffering in silence through avoidance and denial (Ogrodniczuk & Oliffe, 2010b).

Adherence to socially acceptable masculine role norms can prevent men from seeking help for depression (Addis, 2008; Branney & White, 2008: Courtenay, 2000; Safford, 2008 and Noone & Stephens, 2008). Men make treatment choices that rely heavily on self-management strategies like substance use and other avoidance techniques (Addis, 2008; Branney & White, 2008; Brownhill et al., 2005: Courtenay, 2000 and Safford, 2008). Socially acceptable masculine role norms including drinking large amounts of alcohol and over-working, are embraced by men to keep depression private (Brownhill et al., 2005; Chuick et al., 2009 and Mahalik & Rochlen, 2006) affording them public complicity with other acceptable masculine ideals like independence and strength (Addis, 2008; Branney & White, 2008; Brownhill et al., 2005 and Courtenay, 2000).

Common themes reported in the literature related to masculine role discord among depressed men include their desire to appear competent and self-reliant, (Addis, 2008), powerful and successful (Ogrodniczuk & Oliffe, 2010b) virile (Courtenay, 2000) strong (Emslie et al., 2006; Oliffe et al., 2010 and Oliffe et al., 2011); and courageous (Johnson et al., 2012). Also reported were patterns of self-management that lead to avoidance behaviours including substance use and reliance on female partners for emotional support (Brownhill et al., 2005; Chuick et al., 2009: Emslie et al., 2006: Mahalik & Rochlen, 2006: Oliffe et al., 2011 and Oliffe et al., 2012). Men reported efforts to hide depression and engage in activities including over-working leading others to believe that they were successfully living up to socially acceptable masculine norms (Brownhill et al., 2005; Johnson et al., 2012 and Oliffe et al., 2010). Another common
finding among these studies was the emphasis that men placed on the importance of help-seeking being recognized as strength-based (Chuick et al., 2009; Emslie et al., 2006 and Johnson et al., 2012).

The current study adds to the literature by highlighting how beliefs about masculinity affect the heterosexual relationships of depressed men. This study further addresses knowledge gaps regarding heterosexual men’s depression-related help-seeking and the role women partners play.

2.3 Men’s depression-related health services

Social stigma and negativity associated with mental illnesses like depression present men with added pressure to maintain secrecy regarding their condition and influences decisions regarding the types of depression-related health services they choose to engage with (Johnson et al., 2012). The types of depression-related health services depressed men report engaging with include visiting their general practitioners, internet-based programs, talk therapy and group therapy (McCusker & Galupo, 2011; Ogrodniczuk & Oliffe, 2009; Ryan, Shochet & Stallman, 2010 and Wilhelm, 2009).

In his clinical treatment recommendations, Kilmartin (2005) outlined several important considerations for health care providers to consider when providing depression-related health services for men. He recommended policies be developed to target services for men experiencing depression by appealing to their beliefs about masculine ideals including the importance of appearing self-sufficient and in emotional control (Kilmartin, 2005). Kilmartin cleverly depicted five stereotypical traits central to what he described as male pressures to conform to “cultural masculinity” (p. 96) including pressure to be courageous, independent and assertive while acting as leaders among men who take on the challenge of fighting depression. The framework was
intended to assist health care providers in acknowledging their clients’ masculine belief structures while encouraging them to engage with positive management strategies and depression-related health services (Kilmartin, 2005).

Similarly, Ogrodniczuk and Oliffe (2009) made recommendations for health care providers working with depressed men and designing services to assist them in overcoming challenges with help-seeking. The authors further addressed difficulties in providing effective depression-related health services for men in two clinical treatment recommendation articles (Ogrodniczuk & Oliffe, 2009). The first cautioned health care providers regarding men’s propensity to use denial as a coping strategy when attempting to manage depression. They suggested that depressed men might present clinically as stressed which might contribute to improper diagnosis and poor treatment outcomes (Ogrodniczuk & Oliffe, 2010a). A second article suggested that men are susceptible to “suffering silently” (p. 8) in an effort to conform to their hegemonic masculine belief systems (Ogrodniczuk & Oliffe, 2010b). The men in this study reported that they would withhold discussing their feelings as a preferable alternative to appearing weak to their partners, peers or health care providers (Ogrodniczuk & Oliffe, 2010b).

In each of these articles, Ogrodniczuk and Oliffe (2010a & 2010b) discussed how men express their challenges with depression stating that men will more commonly describe difficult to manage physical symptoms associated with depression such as fatigue to their health care providers and omit the fact that they may be feeling sad. The authors also highlighted the fact that depressed men are more likely to attempt suicide than women, suggesting that it is imperative health care providers become more attuned to recognizing depression warning signs in men (Ogrodniczuk & Oliffe, 2010a; 2010b). The researchers also advocated for public health campaigns that target men using...
language celebrating the strength and courage it takes to seek help and treat depression (Ogrodniczuk & Oliffe, 2010a; 2010b). Along similar lines, Oliffe and Phillips (2008) earlier suggested that health initiatives must specifically target men through appealing to traditional masculine ideals including the desire to appear courageous, strong and powerful.

Noone and Stephens (2008) examined the effect of socially acceptable masculine ideals by interviewing men regarding their beliefs about engaging with health care services, help-seeking and masculinity; two main themes were highlighted. Men described themselves as “legitimate users” (p. 720) of health care services because they selectively sought the advice of a health care provider only when absolutely necessary, such as in times of crisis or distress (Noone & Stephens, 2008). Conversely, some participants shared their belief that part of subscribing to hegemonic masculinity includes acting as a leader among men and setting an example for good health by engaging in the appropriate use of health services for issues that arise separate from crisis events (Noone & Stephens, 2008).

While Noone and Stephens (2008) identified two main motivations for men to engage with health services, the following discussion helps to shed light on the specific types of services depressed men report to be the most beneficial. Men report they are more likely to engage in less traditional, talk-based treatments that provide goal-oriented activities to act on their depression (Oliffe & Phillips, 2008). Branney and White (2008) further supported the idea that men prefer to engage services that present a clearly delineated action plan with tools they can use to mitigate the negative effects of specific depressive symptoms.

Following along with the concept that depressed men choose to engage with less
traditional avenues for treatment (Oliffe & Phillips, 2008), developing services to meet this need is critical. In a study by Ryan et al. (2010), sixty percent of college men experiencing depression reported their willingness to engage in online depression-related intervention services particularly if they were experiencing high levels of distress. Innovative services that are internet-based and aimed at allowing men to maintain anonymity when engaging in help-seeking must be an integral component in public health program planning and policy development (Ryan et al., 2010).

In a contrasting theme, Kilmartin (2005) and Wilhelm (2009) discussed that men report being more likely to engage traditional, depression-related health services if they feel safe to express their feelings. Kilmartin specifically advocated that health care providers guide men in positive risk taking exercises that allow expression of feelings rather than engaging in unhealthy, avoidant self-management strategies. Recognizing that men might require heightened sensitivity from health care providers, Wilhelm further suggested that clients and practitioners work toward creating a shared understanding of the strength and courage it takes for men to exercise leadership qualities by accessing men’s depression-related health services. Men’s depression-related health services should further encourage clients to set a positive example for other men struggling with depression, take charge of expressing their true identities, tackle the obstacles that are standing in the way of achieving optimal health and cultivate positive relationships with supporters (Kilmartin, 2005).

McCusker and Galupo (2011) further supported Wilhelm’s 2009 argument that men will choose to engage with traditional depression-related health services under the right circumstances. Discussed was, the concept that men are equally as likely as women to continue with therapy for depression once they start, particularly if they subscribe to
less traditional belief structures regarding their masculinity (McCusker & Galupo, 2011). McCusker and Galupo suggested three components could encourage depressed men to engage with depression-related health services. First, public health campaigns should be developed that specifically target the benefits of treatment for depression on key areas of traditional masculine success. Second, advertising awareness campaigns should be placed in public places such as sports arenas aimed at showcasing the positive effects of good mental health on social success. Third, lowering societal stigma regarding mental illness through media messages with celebrity endorsements from professional athletes and celebrities might encourage more depressed men to seek help.

Along similar lines, Noone and Stephens (2008) also proposed that services targeting depressed men should be focused on messaging that appeals to those with strong hegemonic masculine beliefs. Suggesting that health services for men’s depression should use language that incorporates traits associated with dominant masculinity such as strength, knowledge, power and leadership (Noone & Stephens, 2008). Hammer and Vogel (2010) clearly summarized this concept stating that men’s depression-related health services must “directly challenge the misconception that seeking help is a sign of weakness” (p. 307). Advertising campaigns should outline how health services can help men to attack depression through presenting data citing the benefits of early intervention and include testimonials from men who have had successful treatment outcomes (Hammer & Vogel, 2010).

Mahalik et al. (2007) further supported this strategy suggesting that public health messaging could be used to draw men into depression related services that aim to assist in achieving culturally acceptable masculine traits such as developing leadership skills and achieving success as a provider. They proposed that men’s depression-related health
services could be aimed at celebrating achieving an idealized form of masculinity by suggesting that optimal health through treatment for depression can increase employment opportunities and work/career success (Mahalik et al., 2007).

Common findings among these articles on recommendations for men’s depression-related health services include the importance of public health messaging that incorporates language that appeals to desirable masculine traits like courage and leadership (Kilmartin, 2005; McCusker & Galupo, 2011: Noone & Stephens, 2008: Ogrodniczuk & Oliffe, 2009: Ogrodniczuk & Oliffe, 2010a; 2010b and Wilhelm, 2009). Campaigns must be visible in public spaces frequented by men and contain concepts that are aimed at presenting a solution (action-oriented treatment plans) to a problem (depression) that will have a direct impact on improving quality of life (Hammer & Vogel, 2010; Mahalik et al., 2007; McCusker & Galupo, 2011 and Oliffe & Phillips, 2008). A common thread emerged from the literature; some participants shared the idea that it is acceptable for strong, independent men to act as leaders by setting a good example for others to follow as they address their mental health concerns by engaging with appropriate health services (Chuick et al., 2009; Emslie et al., 2006: Johnson et al., 2012 and Noone & Stephens, 2008).

The current research will add to these findings by highlighting depressed men’s perceptions about suitable depression-related health services and the key role women partners can play in helping overcome depression.

2.4 Conclusion

The literature reviewed here reveals complex help-seeking patterns among men who experience depression. Treatment and health promotion programs should be guided by assertions that men must feel empowered to seek help and have the support of their
women partners throughout their treatment journey (Chuick et al., 2009). Women are key influencers of men’s health. The current research further examines heterosexual relationship dynamics regarding men’s depression-related help-seeking behaviours.
Chapter 3: Methods

3.1 Research questions

As discussed in the literature review, complex relationships exist regarding connections between masculinities, men’s depression, help-seeking and heterosexual relationships. This secondary analysis utilized a sub-group of 20 interviews of depressed men taken from a larger data set of 38. The goal of the original study was to examine “heterosexual gender relations in the context of men’s depression” (Oliffe et al., 2011, p. 775). The goal of this thesis is to describe connections between masculinities, men’s depression, help-seeking and heterosexual relationships as a means to better understanding the needs of men who experience depression and the families who support them. The following two research questions were addressed:

1. What are the connections between masculinities, men’s depression, help-seeking and heterosexual relationships?
2. How do men who experience depression perceive their women partners’ efforts to help?

3.2 Methodology

3.2.1 Interpretive description

This descriptive qualitative study utilized interpretive description analysis to examine men’s depression. Interpretive description allows researchers to acquire an understanding of individuals and their unique experiences by examining data gathered through interview techniques that allow questions to be answered with a goal of informing clinical health care practice (Thorne, 2008). Interpretive description studies are also rooted in what is already known about a topic, and are conducted in such a manner to add to the existing literature by complementing previous work and providing new avenues of insight to specific themes emerging from the data analysis (Thorne, 1997).
This method of analysis identifies patterns and themes that emerge in the data suggesting common experiences among the participants while also allowing for unique perspectives to be highlighted (Thorne, Reimer Kirkham & O’Flynn-Magee, 2004). An interpretive description analysis, when combined with a thorough literature review, enabled an investigation of the concept of depressed men’s perceptions of their women partners’ efforts to help and men’s depression-related help-seeking by looking for meaning in an existing data set in an effort to augment what is already known (Streubert-Speziale & Carpenter, 2007; Thorne, 2000).

The method of interpretive description secondary analysis used in this thesis differs in that it used an inductive reasoning process whereby the researcher made observations based on interview data previously collected from men who experience depression. Connell’s (2005) masculinities framework guided the interpretive process of data analysis such that hegemonic masculine ideals referred to by the participants were used to inform the development of themes regarding how the participants perceived their intimate partner support and their experiences with help-seeking for depression.

3.3 Procedures & data collection from the primary study

3.3.1 Recruitment strategies

The original team of researchers recruited the participants by using postcards and print materials that they placed in physician’s offices and mental health clinics around the city of Vancouver. They also placed advertisements in local newspapers and discussed the purpose of the study with local Vancouver media to invite potential participants to contact the project manager.
3.3.2 Examination of the primary study’s data collection

The original research team obtained consent from the participants and held individual, semi-structured interviews with each participant conducted in 2008 and 2009 lasting 60-90 minutes. Participants were paid an Honourarium of $30 and interviewers explained that the purpose of the study was to gain understanding of couple dynamics in the context of men’s depression. The participants completed the 21-item Beck Depression Inventory (BDI-II) scale to report their level of depression and each was provided with a list of mental health resources. The BDI score uses the following scales: a score of 0–9 indicates minimal depression, 10–18 indicates mild depression, 19–29 indicates moderate depression and 30–63 indicates severe depression. The interviews were recorded with digital recorders and transcribed verbatim. The current study included 12 participants (60%) with BDI scores in the moderate to severely depressed range. The current research used a sub-group consisting of 20 participants chosen in consultation with the original study’s principal investigator.

3.4 Secondary analysis

An interpretive descriptive approach lends itself well to a secondary analysis, as one of the main goals is to incorporate additional analyses of data to advance knowledge on particular topic areas (Thorne, 2008). This thesis is a secondary analysis of 20 interview transcripts drawn from a larger data set of 38 heterosexual men who experience depression. The sub-group ranged in age from 25-48 years and they resided in the greater Vancouver area. A secondary analysis design allowed for raw data to be re-worked while asking novel questions and searching for new themes that were not unearthed in the primary research (Heaton, 2008).

Benefits of secondary analysis research include reduced data collection costs and
amplifying the voices of the original participants such that their effort and commitment are rewarded through multiple analyses (Hinds, Vogel, & Clarke-Steffen, 1997). The current research examined and highlighted previously unexplored meanings from the original study’s data including depressed men’s perceptions of their women partners’ support and the influence of gender on men’s depression-related help-seeking (Heaton, 2008). Thorne (1998) discussed how the use of secondary analysis is especially beneficial in qualitative research that addresses emotionally sensitive topics such as depression as it may be less challenging or comforting for participants to share their experiences knowing their contributions inform and expand knowledge beyond the original study. Stajduhar, Thorne, McGuiness and Kim Sing (2010) exemplified this concept by highlighting the benefits of re-using data in cases where sensitive subject matter was involved.

While there are benefits to secondary analysis, there are also challenges. It is essential that researchers ensure that the questions being asked of the data set are capable of being answered, and that the secondary findings do not differ so greatly from the original research that the conclusions drawn retain a sense of congruency (Thorne, 1998). Working closely with the primary researcher is one way to mitigate this potential problem and Thorne (1998) labeled this type of secondary analysis as retrospective interpretation as it further develops themes that might also have emerged in the original research but were not fully examined. Thorne also warned that it is sometimes difficult to justify procedural decisions in the data analysis process, as there is no clear-cut methodology to follow for secondary analysis. The current study combines secondary analysis with interpretive description methods in an effort to create a clear audit trail of all decisions made and to prevent the researcher from straying too far from the original research questions and purpose.
Researchers must be careful to not over amplify data, as they were not part of the data collection and are unable to benefit from direct observations that would help to clarify the meaning behind certain participant responses (Thorne, 1998). Researchers also run the risk of fitting data into pre-conceived ideas about the topic because they are typically working with a select, smaller sample of the original research. Careful attention was paid to developing a clear audit trail to ensure that the participants’ voices in the current study were fairly represented (Hinds et al., 1997; Thorne, 2008). This concept is referred to as trustworthiness in qualitative research, allowing for transparency of the analytic processes and providing an analytic map that can be examined by others (Polit & Beck, 2008).

3.4.1 Study limitations

Findings from this qualitative, interpretive descriptive secondary analysis are not espoused as transferable to other populations of depressed men as key influences including geographic and relationship factors might not affect the life experience of other groups of men. A further limitation of the study design is that the findings and interpretations of the participants’ experiences with depression were the product of a secondary analysis and the researcher was unable to draw upon personal interactions with the participants (Thorne, 1998). Thorne (1998) discussed this secondary analysis research limitation using the term fidelity, which she defined as “the obligation for truth telling” (p. 552).

3.5 Sample

Decisions regarding inclusion criteria for participants in this secondary analysis study were made in consultation with the principal investigator of the original research. Specifically, participants were depressed men ranging in age from 22-48 years from the
greater Vancouver area which led to an urban-based analysis, and afforded a glimpse into the lives of depressed men living in this west coast, multicultural city. The educational background of the participants ranged from some high school to graduate degrees, half were unemployed and all lived with their women partners. The participants’ BDI scores ranged from minimal to severe indicating that all participants suffered from depression; 35% with a sever designation. As it was imperative that the participants have direct experience with men’s depression, this sampling strategy was an appropriate choice for an interpretive description analysis (van Manen, 1997). Participant demographic data are presented in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of participants</th>
<th>Age range</th>
<th>BDI scores</th>
<th>Employment status</th>
<th>Living with partner</th>
<th>Treatment for depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo-Canadian</td>
<td>13</td>
<td>22-48 years Mean=35 years</td>
<td>Minimal n=3</td>
<td>Employed n=10</td>
<td>All 20 participants lived with women partners</td>
<td>Yes n=11</td>
</tr>
<tr>
<td>First Nations</td>
<td>4</td>
<td></td>
<td>Mild n=5 Moderate n=5 Severe n=7</td>
<td>Unemployed n=10</td>
<td></td>
<td>No n=9</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.6 Ethical considerations

Ethics approval was obtained for the primary study and included approval for secondary analysis of the interview transcripts. Participant privacy and confidentiality were safeguarded throughout this secondary analysis (Streubert-Speziale & Carpenter, 2007). Data chosen for analysis in the study did not include participant personal information as unique coded identifiers were assigned to each participant’s interview transcripts by the primary researchers.
3.7 Data Analysis

In analyzing the data for the current study, Thorne’s (2000) “recipe” for doing interpretive description analysis was followed. Thorne et al. (2004) suggested utilizing Morse’s (1994) terminology: comprehending data, synthesizing meanings, theorizing relationships and recontextualizing data into findings. Data comprehension was achieved when patterns became apparent among the identified themes for each research question (Morse, 1994). Meaning synthesis occurred when smaller, less significant concepts were subsumed or collapsed into larger, more over-arching themes (Morse, 1994). This process allowed for a deeper level of understanding such that subtle nuances in how different participants described “hiding” became evident that were not obvious in the preliminary stages of analysis. Thorne et al. (2004) described the process of theorizing as continuing to reflect on the data and emergent patterns by constantly asking questions including “why is this here?” and “why not something else?” (p. 7) while continuing to challenge interpretations throughout the data analysis.

Preliminary interpretations of the entire data set were recorded in order to develop research questions ahead of re-reading the transcripts to look for initial ideas about tentative themes. Track changes were used in Microsoft Word™ to highlight and insert notes about preliminary interpretations of the data. Re-reading of the transcripts then proceeded through multiple cycles, each with more specific focus being drawn to the areas that addressed each research question. Broad concepts began to emerge regarding participants’ responses about partner support amid their efforts to seek help for depression. Themes were identified as patterns relating to the two research questions emerged and notes were made reflecting on the analytic process and tentative themes.
Once themes were identified during the data analysis, sections of data from the original transcripts were cut and pasted into a Microsoft Word™ file and grouped according to themes. The findings were divided into two sections according to which research question they addressed. Once data segments were divided into two groups, the transcripts were further analyzed to ascertain which participants gave responses congruent with each theme. The most prominent themes relating to each research question were then inductively derived. Chapter four presents these findings along with illustrative participant quotes.

Raw chunks of data from the interview transcripts were grouped, using broad terms such as “shield”, “hiding”, “protect”, “withdrawal”, “caretaking” and “advice”. Data was organized into these and other large categories and then interpreted to distill common themes. In returning to the preliminary findings, some concepts were subsumed to describe the issues that presided within and across the men’s interviews. Other concepts that stood out as isolated ideas were highlighted and reflected on to ensure that all of the participants’ voices were included to ensure the overall trustworthiness of the findings (Lincoln & Guba, 1985). The findings were then considered in relation to masculinities and masculine ideals to explore connections to gender frameworks (Howson, 2006).

Inductive analytic processes were used to search for patterns in the data without prematurely drawing conclusions about lesser representative themes (Thorne, 1997). The qualitative interview data was analyzed looking for themes in an effort to build on previous findings and add to clinical awareness for health care providers about connections between masculinities, men’s depression, help-seeking and heterosexual
relationships as a means to better understanding the needs of men who experience depression and the families who support them (Ryan, Coughlan & Cronin, 2007).

The analytic process was mindful to ensure that this secondary analysis did not over amplify findings such that emergent themes might appear to be more meaningful than the participants originally intended (Thorne, 1998). Thorne (1998) commented that secondary analysis researchers might have the added challenge of avoiding the propensity to “fit” (p. 175) data to answer their research questions because they were not present during the original interviews and might misinterpret the participants’ meaning or assign greater weight to responses that seem to perfectly answer a specific research question. The analytic process presented two instances where this challenge arose and required a step back to reflect for a day to write process notes before proceeding.

In an effort to “prevent premature closure” (p. 5) Thorne et al. (2004) suggested that novice researchers continually question their preconceived notions about the phenomenon under study. Careful consideration was given to this within the analysis of the data; each time a theme emerged that seemed to perfectly answer the research questions or fall into place with obvious perceptions about the topic under study, it became a cue to step back and re-consider, re-think and re-analyze that particular segment of data. Thus, a reasonable amount of comfort was achieved with constantly being “skeptical of the immediately apparent” (p. 5) and it became challenging to look for alternate meanings and examples of participant views that countered these seemingly perfect concepts (Thorne et al., 2004).

3.7.1 Coding for theme and pattern identification

Qualitative researchers describe the process of coding raw data as a process of dividing pieces of interview transcripts into smaller, more manageable sections and
assigning a term that signifies the general meaning (Polit & Beck, 2008). Thorne (2008) discussed this concept as a process analogous to sorting clothes when doing laundry and cautions researchers from using terms that are too specific in order to ensure that they are also considering the data in its entirety. Essentially, getting too specific too soon in the process of data analysis might lead novice researchers down a path of shaping the data to answer their specific research questions rather than allowing the data to speak for itself (Holloway & Wheeler, 2010). The coding process for this thesis was undertaken by keeping in mind the entire data set. As broad code terms were applied to pieces of the transcripts, an iterative process was followed which included spending time with the data and raising questions about emergent patterns (Thorne, 2008).

During the analytical process, careful attention was paid not only to broad emerging patterns and themes in the data but also to themes that emerged as stand alone concepts described by one or two participants. Thorne (2008) advised researchers to thoughtfully consider themes that might only be representative of a small number of participants as it is a meaningful part of the analytical process and allows for questions to be raised that might contribute to further avenues of research.

3.7.2 Comparative analysis

The process of data analysis began by reading through all interview transcripts in their entirety to gain an overall first impression of the data set (Holloway & Wheeler, 2010). The process was reflexive, circular and entailed going from interview transcripts in their entirety to consideration of personal notes and reflections on the data reviewed to delineate the reasoning behind decisions that were made and examination of specific pieces of data for concepts (Rubin & Rubin, 2005). Comparative analyses were conducted going back and forth between transcripts and data segments as emergent
themes were inductively derived (Holloway & Wheeler, 2010). Data analysis included the preceding activities combined with the use of highlighting and track changes in Microsoft Word™ to comment on and call attention to specific segments of the data.

While acknowledging the potential for bias in what was ultimately chosen for inclusion as data examples and interpretations, the influence of gender, conceptions of gender-role stereotypes, ethnicity, socio-economic status and level of education were all considered to ensure the trustworthiness of the findings. In this regard, the process of data analysis was engaged in with an open mind to allow the significance of the concepts to emerge from the data rather than applying pre-conceived ideas about the concept of masculinities, men’s depression, heterosexual relationships and depression-related help-seeking (Charmaz, 2004).

3.7.3 Strategies to ensure rigor in qualitative research

Morse, Barrett, Mayan, Olson and Spiers (2002) stated that: “without rigor, research is worthless, becomes fiction and loses its utility” (p.14). These researchers called for the importance of ensuring rigorous standards are followed throughout the research process rather than simply using a checklist to ascertain if procedures were followed after the research is complete (Morse et al., 2002). The analytic process for the current study employed this approach to ensure that the findings were closely representative of the participants’ perspectives.

While acknowledging potential biases in reviewing and interpreting the data, an audit trail was maintained detailing analytic decisions made throughout the course of analysis (Streubert-Speziale & Carpenter, 2007). For example, personal notes were recorded in a journal as a reflection on the emotional impact of the participants’ stories and process notes were made throughout the analytic process to capture the reasons
behind key decisions around identification of themes and their further theoretical analysis (Sandelowski, 1986).

Careful attention was paid to ensuring what Lincoln and Guba (1985) described as credibility of the analytic process through self-reflection that was documented in the audit trail for this thesis. de Witt and Ploegg (2006) further suggested that qualitative researchers should maintain “openness” (p. 215) with their decision making processes and clearly delineate how their interpretations were derived. With de Witt and Ploegg’s suggestions in mind, the concept of “balanced integration” (p. 215) was employed whereby feedback from the primary study’s principal investigator regarding emergent themes was considered as a means to advancing the interpretive descriptive analysis (de Witt & Ploegg, 2006).

3.7.4 Conceptualizing findings

Interpretive description in qualitative research has, at its roots, the underlying goal of looking for meaning from the research process such that the participants share their stories and the researcher(s) leverage the findings to make recommendations for improving clinical practice and/or guiding policy development (Thorne, 2008).

The final step in Thorne’s (2000) “recipe” for interpretive description data analysis is recontextualization of the data into findings and this was accomplished through the creation of descriptions of the participants’ perceptions of their women partners’ support and how gender influences depression-related help-seeking (Morse, 1994). The findings can build on the knowledge base regarding the complexities of the challenges depressed men have in their heterosexual relationships and with their depression-related help-seeking (Thorne et al., 2004).
Chapter 4: Research Findings

4.1 Introduction & common findings

Themes were identified related to each research question and chapter four presents the findings in two sections divided according to the research question they addressed. The first section addresses research question one: what are the connections between masculinities, men’s depression, help-seeking and heterosexual relationships? and is organized according to an overarching theme “it’s not okay to ask for help”. This section describes four themes along with illustrative participant quotes: (1) hiding depression, (2) self-managing while resisting help, (3) partner relationships are critical and (4) advice to other men. Illustrative participant quotes are linked by age and relationship status. The second section is titled “I just need her to be there and to give me hope” and presents three themes to address the second research question: how do men who experience depression perceive their women partners’ efforts to help? The themes include: (1) partners as supportive caretakers, (2) importance of acceptance and affection and (3) protecting and shielding partners. Some of the themes presented in this analysis are interrelated; for example the women partners might act as supportive caretakers by exhibiting acceptance of their partner’s depression and demonstrating physical affection.

Three of the men specifically shared details about abusive pasts and eight men shared problems with substance use. Several of the men divulged ineffectual attempts at self-medicating and avoiding depressive symptoms including using alcohol and other substances. Almost all participants expressed feelings of low self-confidence and fear of failure related to living up to their traditional masculine ideals and being a reliable “provider”. The men noted that these feelings contributed to their depression and led to self-isolation and social withdrawal. Finally, many reported having few male friends and
feelings of regret with regard to their perceptions that they were not adequately fulfilling what they perceived to be an ideal masculine role.

4.2 “It’s not okay to ask for help”

Participants discussed many reasons for refusing to alert others to their depression and choosing not to seek help. An interesting pattern emerged regarding how the manner in which the age of the participants and their relationship status might affect these choices possibly in light of their changing beliefs about traditional masculine ideals. Four themes emerged in the analysis of research question one including: 1) hiding depression, 2) self-managing while resisting help, 3) partner relationships are critical and 4) advice to other men.

4.2.1 Hiding depression

The participants described efforts to keep depression hidden and their desire to outwardly project strength. They experienced pressure to conform to socially acceptable masculine ideals by hiding perceived weakness from their families, colleagues and peers. Many men stated that the only person they talked about depression with was their wife or girlfriend. However, an interesting pattern emerged whereby several participants revealed that they made an active choice to hide the most severe aspects of their depression from their women partners. A 37-year-old, man who lived with his girlfriend shared:

Women have been taught to be open with their feelings and they share with each other, men are taught that we’re not allowed to share these feelings, you have to be strong in that and keep all these things in check. You put up this false front that you’re strong, you’re confident and you have everything together when, in fact, you’re the exact opposite of all those things…we’re still trying to hide from what’s hurting us. I keep it hidden, it’s not something that I’m proud of.
He explained how being a man meant keeping his depression hidden signaling that men are socialized to withhold their feelings and ultimately choose silence. Interestingly, this silence could extend to their heterosexual relationships when men chose to withhold information about their depression from women partners. While participants shared they had confided in their women partners, some men were selective about what aspects of their depression were disclosed.

A married, participant, age 37, used the phrase “culture of a stoic warrior” in describing his battle to keep depression hidden. It was critical for this participant to appear capable of facing life’s challenges when socializing with other men. Participants shared concerns about keeping depression hidden fearing stigmatization and ostracism. Pressure to keep depression hidden was expressed by many participants and included a reluctance to talk to women partners, friends, colleagues or health care providers. Hiding depression included presenting as strong to those around them despite knowing they were playing a masculine role they felt others expected of them. This was also described and summarized by a 26-year-old, married participant who, when asked to describe a typical man, said “(he) hides his feelings, thinks he’s strong”. Hiding depression also required energy and was reliant on the context as a 30-year-old, married man similarly stated:

It totally depends on the environment, um, and how I’m feeling at the time, whether, to what degree I can get over myself and get out there and be social and smile and put on a brave face.

This participant also stated that he would withdraw socially if he did not have the energy to hide his depression; this sentiment was similarly disclosed by several other participants. A married, 27-year-old man stated he would “hide it and just hope for it to go away” while a 44-year-old man in a common-law relationship said:
A lot of guys they won’t admit that there’s a problem, even when clearly there is a problem and you still keep saying there isn’t, I think that’s probably, mostly pride, you know, too much of a man to admit that there might be a problem or might be depressed.

Within this context, hiding depression from others could also afford opportunities to deny the existence of depression to oneself. The effectiveness of hiding depression was however, provisional. As a married man, age 30, with a family history of depression said:

I don’t like drawing attention to myself; that’s probably why they don’t notice it as much…so yeah I generally neglect to mention it, it’s not common knowledge, but anyone who’s known me for a period of time must know that I’m pretty moody.

While many participants discussed their efforts to hide depression, they also mentioned an awareness of depression in other men and an understanding that despite their best efforts at concealment, others might still be able to see depression in them. Several participants discussed the lows of depression using powerful imagery. A 24-year-old man with a girlfriend called the lows of depression going to the “dark side” and shared that he could sense when other men around him were in the same depressed place as he was. A married participant, age 37, shared:

I try and be happy go lucky guy but it’s a false front right, but when you’re depressed you can see (others) are depressed like they’re walking in death.

Another married participant, age 28, also discussed his awareness of depression in other men and said “I wish I talked to men more about their health issues, but I don’t…it just feels uncomfortable”. Finally, a 37-year-old married man struggling suggested that hiding his depression could also protect others from the pain he felt:
You’d really hate to be trapped in this head, so when people ask me what I’m thinking, I have to be very careful that I don’t actually tell them.

Men might choose to hide the most severe aspects of their depression from their women partners who are often their most significant and supportive caretakers. However, despite their efforts at concealment, the participants in the current research shared their awareness of depression in other men. The participants also stated that their women partners possessed the ability to detect depression even if it was left undisclosed.

4.2.2 Self-managing while resisting help

Participants expressed their efforts to self-manage depression in myriad ways. Kilmartin (2005) commented that men who ascribe to traditional masculine ideals including the desire to appear unemotional and invulnerable are more likely to attempt self-managing depression. A 26-year-old, married man said he preferred to “wait it out” when describing how he managed his depression. Another married man, age 42, shared that he “suffered through it” while a participant who lived with his girlfriend, age 24, stated “I feel strong that I am not a slave to anything” when he explained that he would resist pharmacotherapy. A 37-year-old married participant with a history of substance overuse shared that he would self-medicate with “anything that would numb”. These participants all described similar depressive symptoms including fatigue and difficulty with motivation, which many of the men had tried to self-manage with substance use.

Several men explained how their women partners encouraged them to make positive choices regarding their depression self-management. A married participant, age 30, shared how his partner helped him manage depression and its negative symptoms by saying how she encouraged him to “accomplish things in life” rather than resorting to
ineffectually using substances or withdrawing socially. A 37-year-old man who lived with his girlfriend said:

Through our walks and talks, you know, she was very supportive, you know, everything I told her she was very supportive of me.

This participant went on to elaborate how his partner encouraged him to share his feelings as a means to jointly deciding on positive coping strategies including shared exercise and taking time to reflect on daily stressors.

A 37-year-old, married man said “its not okay to ask for help, its not okay to admit any kind of weakness” a sentiment echoed by several other participants. A participant with a girlfriend, age 24, used the term “avoiding weakness” in describing his reasons for choosing self-management over seeking help for depression. Participants also discussed being influenced by masculine ideals including the desire to appear strong and steadfast in self-managing their depression. A 30-year-old, married man shared his “fear of breaking, of being exposed, or appearing weak” should his self-management efforts falter. A participant in a common-law relationship, age 44, addressed similar feelings explaining how he would “just go silent” in an attempt to self-manage what he thought was visible to others with regard to his depression. Silence signaled the traditional masculine ideal of strength and was a key self-management strategy that was commonly described by many participants.

A 36-year-old, participant with a girlfriend stated:

They (health care providers) have a large caseload for low-income people such as myself, so there’s a lot of people that they have on a regular basis and sometimes they have to be involved in crisis with them or whatever their case may be, so they don’t have the time.
Mechanistic and health care system issues were also discussed by participants in the context of needing to self-manage, rather than appearing reliant on outside help. This participant further explained that negative experiences with the health care providers he initially interacted with, eventually led him to end treatment and focus entirely on self-management strategies.

Conversely, some participants described failed attempts at self-management as a critical element in the decision-making process that eventually led to engagement with depression-related health services. A 36-year-old man who lived with his girlfriend shared that he was “expecting the worst and hoping for the best” with regard to reluctantly deciding to engage in treatment for depression. He disclosed that he made the choice to seek help after realizing that his attempts at self-management were unsuccessful and his depression became so severe that he was having suicidal thoughts.

A 24-year-old with a girlfriend, said:

After I solved the problem myself or I get out of the situation by being alone, on my self; I feel somehow proud. I hate being dependent on the others. I like others to be dependent on me. When one is depressed he thinks that by seeking help and by going to somebody he is just giving the others some sort of bad impression.

These participants described their motivation to self-manage depression as related to their desire to avoid the appearance of not living up to their masculine ideals. Many men believed there was weakness or vulnerability in admitting they needed help. Many of the men also reported enlisting the support of their women partners in selecting effective self-management strategies.

Two opposing sentiments regarding resisting help were reflected on by the participants. Many participants shared the view that weakness came with being reliant on
others while some men argued that it took strength to ask for help. Many participants stated that help-seeking is okay for other men but not for themselves demonstrating a division in their beliefs about the acceptibility for men to seek help for depression. These discordant views also emerged in the context of the men’s heterosexual relationships. A participant with a girlfriend, age 24, shared his reticence to engage in treatment when asked about his thoughts about help-seeking for depression:

No, I haven’t had any treatment. She (partner) wanted me to go but I wasn’t comfortable.

While many participants shared their discomfort in help-seeking, they also shared how their women partners encouraged, advised and directed them to do so.

A 28-year-old married participant with an extensive treatment history for depression, advised other men to realize the supportive role of their women partners in self-management:

She’s a good role model. Like, like she does things whether she feels like it or not. Which is, like, basically the cure for depression. At the end of the day, we’re going to come home and talk to each other, it’s good to debrief and like I’ll just tell her all about my day…it’s a really good relapse prevention strategy for depression.

A 27-year-old married man and a 36-year-old man who lived with his girlfriend, said “when my wife tells me that I have to” and “I agreed because I wanted to make her happy” when discussing their motivations behind seeking help for depression. A 26-year-old married participant said: “whatever she asks of me, I do it” when asked how his partner influenced him to seek treatment. This group of participants stated they would not have sought help on their own accord disclosing that they did so only because their
women partners directed them to. In these instances, the influence of being in a relationship was beneficial from a health promotion perspective; these men reported that they would only seek help for depression because their women partners insisted they do so.

Resisting help and equating it with the inability to act in an ideally self-reliant manner was a theme shared by many participants. A 30-year-old married participant described this concept when he shared:

I’m used to relying on myself, where I’m very independent, I don’t like asking other people for help, um, when I do I feel extremely guilty, so, so yeah, my challenges in seeking help is that I’ve never sought it.

The same participant also stated: “I would definitely be more comfortable suggesting other people seek help than seeking help myself” which is a sentiment echoed by others. A 30-year-old married participant also explained his resistance toward help-seeking in the following statement:

Well I’ve never really sorted it out really…I think a lot of it, has to do with just the image of you know, being a man right, you don’t ask for help, you don’t show weakness essentially.

A 42-year-old man with a girlfriend said: “it’s a stigma (depression), and men are supposed to be more masculine, you’re supposed to be stronger…mentally as well as physically” in reference to his reluctance to seek help. Finally, a 24-year-old, also with a girlfriend said: “I wasn’t really comfortable going to a therapist because I felt like if talking can help me then I can help myself” when explaining the reason for his refusal to seek help for depression.
A 44-year-old participant in a common-law relationship suggested a contrasting idea: that other depressed men should “just talk to a person, it might make you feel better just to talk to someone” but went on to say that he would not be comfortable seeking help himself.

A 37-year-old participant living with his girlfriend stated: “it’s hard to talk to somebody who thinks the world is all rainbows and kittens” when discussing his difficulty relating to others about the severity of his depression. This participant explained his discomfort with sharing the details of the true extent of his negative feelings and experiences with depression.

A 37-year-old man with a girlfriend expressed his approval for men to seek help for depression by describing how he thought it would be acceptable for men to pursue action-oriented treatment. He clarified this in a unique way referring to gender and using action words by saying the “masculine role” in help seeking can be defined by “what you do yourself”. He made it clear that men seeking help for depression would be acceptable only if the treatment plan or program consisted of clear guidelines to follow with specific tools that men could use in helping themselves.

Along similar lines, some participants expressed their view that treatment programs for depressed men should include action oriented care that provides clear, easy to follow steps that men can use while guided by a therapist or physician to help them cope with symptoms of depression and challenge them to engage in the process of recovery. A 26-year-old man in a common-law relationship, clearly articulated this concept by saying that:

Easier access to a psychological professional that I could just go and talk to once a week that could provide me with good rapport, that I felt confident in, trusted
and who could teach me stuff and then give me help in practice implementing their suggestions and help in my real life and real situations but I don’t have enough money to pay for that kind of care.

Once given guidance by a health care provider to follow steps toward recovery from depression, participants stated that they would be likely to actively participate in the process. A 24-year-old participant with a girlfriend shared his feelings about depression-related health services for men:

I think men are really neglected in so many aspects and this is one of them. For example, we have so many clinics and charities or things to help women cope with problems in their life, but do we have the same things for men? No.

This example highlights sentiments shared by several participants that gender neutral health care services are not enough to effectively help depressed men. Another participant, age 37, who lived with his girlfriend stated that he thought health care “professionals need to dig deeper with men because men will say one thing and mean something else”. Both men shared the opinion that health care providers must be cognizant that accessibility to depression-related services that are focused on the unique needs of men is critical.

Resisting help is positively related to believing that seeking help is synonymous with weakness however, some men believe that seeking help is acceptable under the right circumstances. Depression-related health services for men must be action-oriented and goal-directed.

4.2.3 Partner relationships are critical

Depressed men with traditional masculine ideals might choose not to seek help fearing that exposure might allow others to perceive them as weak and vulnerable
(Wilhelm, 2009). Many participants described how their women partners were their only source of support and disclosed that they would be in a deeper state of depression without them. They characterized this concept in several ways including how their partners helped them to communicate, provided motivation to refrain from self-isolating, monitored their mood and suggested they seek help when symptoms became unmanageable. A participant in a common-law relationship, age, 37, shared: “it would be worse without her” in characterizing the key role his relationship with his partner played in managing his depression.

A 37-year-old living with his girlfriend stated “I’d be more depressed if that’s even possible” while another married participant, age 42, said “I’d probably bottle it up inside me” if they did not have their partners in their lives to share in challenges with depression and provide emotional support. A 26-year-old married man shared:

Without her I’m so freakin’ scared…I just hide, I go to my room and hide, I don’t know what to do, where to go; sort of feel lost without her.

A participant with a girlfriend, age 26, said “I need her to encourage me to engage in the world” when discussing how his partner acts as a motivating influence to continue with his schooling and pursue his goals. A 44-year-old man in a common-law relationship stated “I usually go along with whatever she wants to do…things work out better.” The participants revealed that their partners encouraged them to accomplish things in their lives when they might otherwise have preferred to stay home and shut the world out.

Several participants said they would engage in long periods of self-isolation sleeping, playing video games or watching television rather than have relationships with people, do school work or pursue employment opportunities. Participants also expressed
fear of failure regarding pursuing their academic and employment goals as well as fear of rejection in social relationships stating that they would not be able to go after the things they wanted in life without their partner’s support. A 37-year-old, married man said:

She’s always been sort of monitoring…Knowing that she was there always gave me hope, um, and always gave a focus to my life even when there wasn’t anything else to focus on.

This man disclosed how his partner remained vigilant, watching for signs of worsening mood. He shared that he felt alone and “hopeless” without his partner while relying on her to keep him connected to life outside his home and move beyond depression’s inherent limitations including fatigue and feelings of worthlessness.

A 42-year-old, married participant echoed the previous concept regarding the perceptiveness of women partners saying:

She can read me like a book…she’s great…she’s been there with me through thick and thin and there’s nobody that’s greater than her.

Participants shared an awareness that their women partners were able to see things in them that they could not see themselves. Their descriptions imparted a sense of safety in knowing that there was someone in their lives that cared enough to work with them to improve their mental health and participate in their lives.

Finally, a 26-year-old, married man shared the value of his partner’s support when he said:

She tells me that you know, things will be better, doesn’t rain all the time…things are not this bad everywhere, I take it to heart, whatever she tells me, I put faith in her words…the best thing that ever happened to me is that woman, sometimes I take her for granted; wish I didn’t.
This statement summarizes what many participants revealed about their perceptions of the role their women partners played in helping them to manage depression. Every participant stated that they discussed depression with their women partners either in full disclosure or by shielding them from their worst feelings. Even if the men had never sought help or espoused the belief that they did not think treatment would be successful, they confided that they were grateful for the support of their women partners.

4.2.4 Advice to other men

Many participants made statements encouraging other men to seek help for depression. A 44-year-old married man advised “don’t wait” to get help. A married participant, age 43, suggested it can be wise to “share your burden” by reaching out and talking about depression with women partners, friends, family or health care providers. Another married participant, age 42, also echoed these sentiments in advising:

Reach out, you’re not tough, even though it’s embarrassing you feel guilty, you feel weak but it’s the best thing to reach out for help.

This participant suggested men take advantage of the manner in which their women partners can act to promote their emotional health.

A 46-year-old married participant stated:

Most guys will say yeah, yeah, yeah, they’ll go and this, but they won’t go, I am a man of my word, if I say I go, I go…quit being so frigging bullheaded and just go, walk the talk. You talk it, you walk it. You say it, you do it. Worry about the end results and all that bullshit later, live up to what you say.

This was a direct challenge to other depressed men to start “manning up” (p. 931) and becoming part of the solution in seeking help for their depression (Ogrodniczuk & Oliffe, 2010). A 42-year-old married participant said “if you’re involved in the process, you
certainly get a lot more out of it” and encouraged men to actively engage in treatment for depression. These participants shared the common viewpoint that men can affect positive change in their lives through seeking help if they are willing to employ strategies and use skills learned during treatment to manage depression.

A participant with a girlfriend, age 24, shared, “I think talking sometimes helps and it helps you understand yourself” while a married participant, age 48, advised:

Try to find help, try to help yourself…talk about it, it helps, it does help and I don’t care how bad of depression you’re in, I know it feels good to express.

These participants voiced their advice to other depressed men about the importance of talk therapy. A married, 30-year-old man further supported this idea stating, “counseling will help you heal and deal with the deeper problem”; suggesting that talk therapy can be beneficial. A 28-year-old married participant said:

I recommend using evidence-based strategies. I recommend seeing a clinical psychologist. I recommend, you know, talking to your GP. I recommend using the Self-Care Depression Program and Depressive Skills at Work. I recommend going with a therapist that you really have a strong rapport with and not sticking with someone who you feel uncomfortable with because it’s not going to be successful. I recommend those things and then like, doing what they teach you. Like actually doing it.

This man disclosed an extensive history of treatment for depression. He made this specific comment regarding his ideas around advising other depressed men based on his personal experiences with help-seeking and the inherent challenges in finding a good fit for efficacious therapy.
While many men advised others to seek help for depression, only 55% (11 of 20) participants reported that they had done so. Several participants stated that it would be okay for other men to seek help for depression but that they would not feel comfortable doing so citing their fears of being stigmatized by others because they have mental illness. Interestingly, many of the men who advised others to engage with men’s depression-related health services were among the older participants in the current study. Speaking from their personal experiences with help-seeking, they advised other men to participate in treatment and to become part of changing the manner in which depressed men manage their condition. The participants’ advice to other men also directly encouraged help-seeking and talking about depression with others in an effort to more widely open lines of communication.

4.3  “I just need her to be there and to give me hope”

Many participants described their women partners as the most important resource in their lives. Three themes emerged in the analysis of research question two including: 1) women partners as supportive caretakers, 2) the importance of acceptance and affection and 3) the desire to protect and shield.

4.3.1  Partners as supportive caretakers

Many participants described failed attempts to self-manage their depression and the crucial nature of their women partners acting as motivators in help-seeking. A 26-year-old, married participant shared that his partner “acts as an outlet, as a stabilizing influence” in his life; helping him through the lows of depression and providing him a safe place to express his feelings. A married man, age 37, said:

When I’m really depressed I just need her to be there and to give me hope and let me know that we’ll get through it. Knowing that she was there always gave me
hope, um, and always gave a focus to my life even when there wasn’t anything else to focus on.

Several participants made reference to the role their partners played in helping them to communicate. A 30-year-old, married man said: “she’s a lot of the time more aware of my feelings than I am” when referring to his wife’s ability to help him give voice to his feelings. A 26-year-old man in a common-law relationship shared:

I communicate badly with my partner about my depression because I don’t have the vocabulary and I don’t have the feelings or thoughts to express this very well.

I’m trying to develop my emotional vocabulary so we can talk about it more.

Another participant with a girlfriend, age 24, said: “I don’t want to talk about it (depression) but usually she is very good to help me communicate”. His partner was supportive and encouraged him to express his feelings; she also encouraged him to open up and engage in a dialogue about his depression. These participants expressed difficulty with communicating and reliance on their partners to initiate conversations about the effects of depression on their lives.

Two 24-year-old, participants with girlfriends said “she helps me do stuff when I’m depressed” and “she convinced me to go out and I felt really good” when explaining how their partners influence their actions. Rather than sitting alone and withdrawing, the women partners encouraged participation in daily life and social relationships. A man with a girlfriend, age 44, shared “she just sort of has that way of putting positive spin on life”. He went on to say that without his partner’s support:

Well I guess I go out less, and less sexually, ‘cause I tend to get more closed up, you know to be more alone when it hits really bad, usually just deal with it
myself, but at times, my partner, she tends to help a lot, I listen to her, and she kind of breaks me out of it sometimes.

These participants described the supportive caretaker roles their women partners played in keeping them socially connected to the outside world. Not only were their women partners patient and supportive, but they were also directly challenging in acting to force the men out of their socially isolated, perceived comfort zones. The participants reported that sometimes this was the only way they would participate in life outside their homes. A 37-year-old man who lived with his girlfriend shared:

When you don’t what to get up out of bed and your partner is all raring to go and they want to go do things and you just don’t feel connected to anything, you disassociate yourself with everyday activity.

in an attempt to describe his girlfriend’s motivating influence to help him participate in daily life.

Women partners act in key caretaking roles for the depressed men in their lives. Depressed men rely heavily on their relationship support to engage in tasks of daily life, limit social withdrawal, discuss their feelings and motivate them to accomplish goals related to employment and academic success.

4.3.2 Importance of acceptance and affection

Participants in the current study described the need for acceptance and affection within the confines of their private partner relationships as a key factor in assisting them with mitigating the negative symptoms of depression. A married man, age 43, shared “she (wife) tries to cheer me up…just some understanding, you know, a few encouraging words.” He described how he needed his partner’s acceptance and affection when he was depressed and feeling emotionally low. Several other men shared similar sentiments
including a 26-year-old, married participant who said “she makes me feel wanted and loved” when discussing how critical it was for him to have his partner’s love. A 46-year-old, married man said “they’re (women) loving, caring people; they’ll give you all the rope in the world” when he described the importance of his partner’s acceptance while he struggled through the most difficult aspects of depression.

Another married participant, age 42, said:

You need somebody in your life to help you live your life; the best way to overcome or deal with your depression is to find someone to help you share your life with.

This participant described how important it was to have a stable relationship with a woman that is accepting and loving when living with the challenges of depression. The same participant also shared how he needed “her arms around me”; when depression was at its worst, highlighting how touch and affection from his partner was an important coping mechanism. A 36-year-old man in a common-law relationship said “I want a hug, I want her to tell me its going to be ok, or tell me that she still loves me” when he described his need for physical affection and expressions of love from his partner. A 44-year-old married man shared how “reminding me that she loves me…lavishes praise…words of affirmation” from his wife were critical in helping him to manage depression. These participants characterized connections with their women partners as essential to helping them to avoid loneliness that could result from depression-induced self-isolation and social withdrawal.

Depressed men rely on their women partners to provide them with love and affection. Acceptance and affection from their women partners helped these men overcome some of the inherently negative effects of some of their ineffective self-
management strategies including choosing social isolation and withdrawal as a means of keeping depression hidden.

4.3.3 Protecting and shielding partners

Efforts to protect and shield their women partners from the negative impact of their depression were described by many participants. While all of the participants revealed confiding in their women partners about their depression, several men confirmed that they drew a line when it came to full disclosure. Some participants described withholding the most troubling aspects of their depressive symptoms and feelings from their partners in an effort to protect them from the worst aspects of their suffering. Many participants shared that they sought comfort from their partners but kept hidden their darkest thoughts and most severe symptomology. Other men chose to turn to substance use a coping mechanism in an effort to spare their partners from the burden of their depression and the toll it took on their relationships.

While efforts were made to conceal the truth, participants stated that they were amazed when their partners could see their depression and offered unsolicited support. A 24-year-old participant with a girlfriend said “I am amazed she can see exactly. She can always tell…she would say, “No, no go to a doctor. Something’s wrong” when he attempted to protect his girlfriend from his depression. A man in a common-law relationship, age 42, shared:

She’s very attuned, after all the time we’ve spent…together, she knows very well, it must be hard on her, I feel guilty about that because I’ve been dragging her into it.

A 36-year-old man, also in a common-law relationship used similar language when he said: “I’m going to drag her down” as the reason behind wanting to shield his partner
from the effects of his depression. Despite their best efforts to shield partners from depression, these participants shared how the women could always tell when they were down and would immediately step into a caretaker role in advising them to seek help and engage with the world around them.

Participants discussed choosing to try to cope with depression alone as an alternative to opening up to their partners and bringing them into their struggle. Several men mentioned that they shielded their partners from the full extent of depression’s negative impact on their lives. Many of the men discussed making decisions to protect their partners from the most severe aspects of their illness by choosing to share only part of how they were truly feeling. A 30-year-old, married man shared:

It helps to have someone to confide in and I can be fairly open with my wife about it, but I never disclose everything.

This participant clearly described how he shielded his partner from depression. He went on to say “because I don’t want her to worry about me or I don’t want to frighten her” which further illustrated his desire to protect his partner from depression’s negative impact.

When discussing the reasoning behind shielding his partner from the true extent of his depression, a 24-year-old man with a girlfriend said:

Right now I have something, then I’d have nothing…she thinks that she cannot rely on me that much…she loses her confidence in me.

This man referred to the possibility that his partner might leave him if she knew the truth about the severity of his depressive symptoms and the negativity of his thoughts. A married participant, age 26, said, “I got a smile painted on my face but inside I’m crying…it’s like I’m wearing a mask” when he described having to hide his depression
from his partner. Protecting their women partners from depression allowed these participants to feel more secure in their relationships, they felt their partners were more confident in them and less likely to leave.

Aspiring to traditional masculine role ideals including acting in proficient provider roles and outwardly projecting strength led many participants to make efforts to prevent full disclosure of the extent of their depression to their women partners. The participants discussed their desire to ensure their partners were not overly burdened by their depression-related challenges.
Chapter 5: Discussion

5.1 Introduction

The findings from this secondary analysis have highlighted connections between masculinities, men’s depression, help-seeking and heterosexual relationships. This analysis provides a means to better understanding the needs of men who experience depression and the families who support them. Chapter five comprises an analysis of how themes, presented in chapter four, relate to previous work on masculinities and depression including comparisons and what the current study findings add to that literature.

5.2 “It’s not okay to ask for help”

5.2.1 Hiding depression

Participants in the current study shared myriad ways that they kept depression hidden including engaging in self-isolation, social withdrawal and substance use. The men also identified several reasons for keeping depression hidden, chiefly citing their desire to outwardly project complicity with desirable, socially acceptable masculine ideals. The participants felt it was critical to hide depression from other men while stating that they were more comfortable discussing their feelings and sharing their emotions with their women partners.

Participants also shared their reluctance to discuss their depression with health care providers or engage with depression-related health services. Other researchers have noted similar findings. Chuick et al., (2009) for example, discussed how culturally dominant, masculine role norms created social pressure preventing men from sharing feelings with others; real men don’t talk about their feelings. Despite stating that they felt comfortable sharing feelings during private consultations with physicians, some
participants disclosed experiences in which they told their health care providers they were experiencing high levels of stress rather than depressive symptoms in an effort to hide what they perceived to be weakness. O’Brien, Hunt and Hart (2005) reported the same pattern in their study whereby men disclosed choosing to directly hide depression from their health care providers or to misrepresent their true feelings and ability to cope with symptoms.

5.2.2 Self-managing while resisting help

Several masculine ideals influenced men’s depression and their choices regarding self-management including the desire to maintain self-reliance, project strength and hide vulnerability. The participants described their difficulties with self-managing depression including reliance on their women partners for emotional support and comfort, withdrawal from social connections with others, fear regarding perceptions of pressure related to fulfilling family provider roles, difficulty concentrating in relation to tasks in the workplace and in accomplishing activities of daily living, self-isolation, concerns with sexual interference, anger, fatigue, decreased motivation and suicidal thoughts.

Similar to the Oliffe et al. (2011) findings, some of the participants in this study reported success in their efforts at self-management and denied that their women partners played major supportive roles in the larger picture of coping.

Several participants in the current study shared how their decision to attempt self-management for depression resulted from concerns with being perceived as weak. If they chose to employ coping strategies that allowed them to keep depression private, they were able to present a strong front in social situations among male peers. Chuick et al. (2009) found a similar theme stating that “depression was not a socially accepted issue for men” (p. 309) and this prevented the men in their study from expressing perceived
weakness to others, while they attempted to self-manage depression. Similar to the findings of Johnson et al. (2012) the men in the current study “guarded their vulnerability” (p. 352) and maintained outward complicity with traditional masculine ideals of strength and self-reliance through coping with depression within the confines of their heterosexual relationships.

The participants described using substances and social withdrawal as two self-management techniques. These strategies allowed the men to engage in socially acceptable male behaviours like drinking alcohol with their peers and to appear to be highly self-sufficient. This finding is in accordance with that of Brownhill et al. (2005) who noted that men who are experiencing depression can find themselves in social situations that celebrate the use of their avoidant self-management strategies; internalizing, maladaptive, self-management techniques can be misconstrued as positive by others in select social situations.

Participants equated help-seeking with weakness. To counteract this negative perception, while outwardly displaying strength, they wanted to be autonomous and private in dealing with their depression. A similar finding was previously described by Johnson et al. (2012) stating that the men in their study identified that the “weakness” (p. 7) displayed by help-seeking illustrated a detrimental failure to achieve the hegemonic masculine ideal of power. Oliffe and Phillips (2008) also discussed how hegemonic masculine ideals including self-reliance and a desire to be seen as powerful might contribute to depressed men equating help-seeking with weakness.

Malcher (2009) argued that health care providers must be mindful about how they approach and offer men health care while remaining cognizant of the challenges men can experience in asking for, as well as receiving help for depression. Participants in the
The current study addressed this challenge stating that health care providers must be aware that men who present in their offices might be constrained by their masculine ideals and unable to express their feelings. This finding was earlier supported by Oliffe and Ogrodniczuk (2010b) when they suggested men might have difficulty explaining how they are feeling emotionally even when they do seek help for depression-related symptoms. Wilhelm (2009) earlier described this concept when she argued that women have greater “emotional literacy” (p. 102) than men and are socialized to express their feelings. In this regard, some of the participants in the current study shared how their women partners played an integral role in helping them develop appropriate language to express their feelings while encouraging the men to seek help for depression.

The current study’s findings also illustrate how strength could be drawn from forging a new path and confronting depression through help-seeking with support from partners, friends and health care providers alike. As previously discussed by Emslie et al. (2006), several participants in the current study shared their feelings of pride in accessing the resources available to them and the courage that it took to do so. Several men related help-seeking with positive masculine ideals including leadership and courage (McCusker & Galupo, 2011). It is imperative that health care providers and depression-related services encourage men to continue to act as leaders in their peer communities through encouraging further discussion beyond the treatment setting in an effort to continue open public dialogue regarding men’s depression (Wilhelm, 2009).

5.2.3 Partner relationships are critical

Many of the participants described their women partners as their only support system. The men noted that they felt comfortable sharing their true feelings with their partners and some shared that they would not feel comfortable talking to anyone else.
The men also described how their women partners were able to recognize their depression and help them with activities of daily living, motivation to engage others socially and perform well in both work and school environments. This finding is similar to Courtenay’s (2000) observation that in attempting to live up to socially acceptable hegemonic masculine ideals, depressed men choose to project strength publically while privately relying heavily on their women partners for support. Mahalik and Rochlen (2006) previously found that men are most likely to confide in their women partners for support when coping with depression.

The ultimate, alarming, example of depression being “worse without her” comes from 70% of the participants disclosing suicidal thoughts or histories of previous suicide attempts. Brownhill et al. (2005) called high suicide rates among depressed men the “ultimate escape” (p. 925) echoing the sentiment of the participants’ concerns regarding long-lasting negative impacts on families. White and Holmes (2006) reported suicide rates to be four times higher in depressed men making it imperative that health care providers be alert and proactive in discussing this concern with their clients. In accordance with findings from Oliffe et al. (2012) participants in the current study shared how they chose not to act on their suicidal thoughts because it was important to live up to traditional masculine ideals including the desire to appear invulnerable and socially acceptable “provider” (p. 509) roles.

5.2.4 Advice to other men

Participants who believed that their depression was a character weakness were reluctant to seek help or completely refused to entertain the idea that they should do so. Martin (2012) similarly commented that men who personally held highly stigmatized
views regarding depression were less likely to seek help particularly when they felt that health care providers might judge them.

Connell (2005) and Gough (2006) suggested that hegemonic masculine ideals create societal power relations that allow men to assert dominance through expressing strength and/or acting aggressively. Several participants in the current research expressed the opinion that men should demonstrate their strength and dominance through tackling the challenges of depression head on and use their power in a positive manner to influence and encourage others to do so as well. The strength and courage it takes for men to admit they have problems should be celebrated. Problems can be overcome with help from health care providers and by engaging with appropriate depression-related health services. Men can act as leaders in their communities and promote social acceptance of depression through disclosure and taking action through treatment to combat its negative effects. Other researchers, including Oliffe and Ogrodniczuk (2009), Wilhelm (2009) and Johnson et al. (2012) have noted similar findings.

It is interesting to note that while many participants advised men to seek-help for depression and speak out to help lower societal stigma, they also shared that they were unwilling to do either themselves. Herein lies a critical issue: men admit that keeping depression hidden is a problem but appear unwilling to be part of a solution that would involve open disclosure in an effort to change public sentiment. The implications of this dichotomy must be considered from a public health perspective. There is a crucial role to be played in educating and socializing boys and young men to embrace positive masculine ideals (Wilhelm, 2009) while engaging in an ongoing, visible public dialogue about the consequences of keeping men’s depression hidden.
5.3  “I just need her to be there and to give me hope”

5.3.1  Partners as supportive caretakers

Many participants in the current study disclosed that they have never sought help from a health care provider for their depression and a key theme became evident regarding the key role women partners play in the daily coping patterns of depressed men. The participants valued the care taking roles of their partners, with several men stating that they could not cope with their depression without them. Oliffe et al. (2011) similarly reported that relationship support from women partners was critical in helping depressed men cope. Some participants stated that their women partners were key to helping them communicate and express their feelings; which acted as an important outlet for managing depressive symptoms.

5.3.2  Importance of acceptance and affection

Many participants shared that they would be unable to cope with their depression if their women partners were not supportive, willing to listen, understanding when they needed space and physically affectionate when they were experiencing particularly negative symptoms. The participants who most strongly ascribed to traditional masculine ideals were less likely to seek help from health care providers and more likely to report reliance on their women partners for emotional support. This finding is in line with the Oliffe et al. (2012) comments regarding men who ascribe to traditional masculine ideals partnering with women who will act in traditional feminine supportive roles that include providing comfort and affection in times of distress.

5.3.3  Protecting and shielding partners

Researchers, including Lyons (2009) and McCusker and Galupo (2011) have described how men work to shield their partners from their depression and self-medicate
negative symptoms while adhering to traditional masculine ideals of strength, independence and invulnerability. Many men in the current study shared their propensity to resort to silence when attempting to protect their women partners from the most severe negative effects of their depression. This finding is congruent with Ogrodniczuk and Oliffe’s (2010b) discussion of men with traditional masculine ideals acting as the “strong silent type” (p. 8) in trying to shield their partners and families from depression while symptoms worsened and they attempted self-management. The participants described isolating themselves from their partners, refusal to seek help from a health care provider and using substances for symptom relief.

5.4 Conclusion

This thesis has presented findings from a secondary analysis on the connections between masculinities, men’s depression, help-seeking and heterosexual relationships. Findings revealed that men might go to great lengths to hide depression amid their desire to achieve complicity with hegemonic masculine ideals. Men will attempt to self-manage depression’s negative symptoms by engaging various coping strategies including substance use and social withdrawal. Depressed men might say that they want help and strongly advise other depressed men to get treatment, but will seldom make efforts to seek it for themselves. Men with depression rely heavily on their women partners as foundations for their private support systems while highly valuing the supportive, affectionate care-taking roles they fulfill. While depressed men might rely on their women partners in crucial support roles, they will also make efforts to shield them from the most negative aspects of their condition. Finally, men living with depression acknowledge that their women partners are critical to their ability to manage symptoms,
accomplish basic tasks of daily living, maintain social connectedness and perform successfully in work and school environments.
Chapter 6: Recommendations

An emergent theme in this secondary analysis is the finding that many men believe that it is important to engage men’s depression-related health services and work with health care providers to manage depression. This concept is central to developing public health programs that allow men the opportunity to access quality care before their experiences with depression develop into a state of crisis. These ideas will be further explored in this section discussing recommendations for men’s depression-related health services.

An effective strategy for raising public awareness highlighted by the current study and other researchers including Ogrodniczuk and Oliffe (2010b) is to re-cast men’s depression-related help-seeking as strength-based, and therefore synonymous with widely held masculine ideals. Health care providers can develop depression-related health services for men that trade on hegemonic masculine ideals and men’s alignment with them (Howson, 2006). Johnson et al. (2012) suggested that men and health care policy makers could work together toward creating positive societal change that celebrates men who are leaders in promoting awareness for men’s depression by taking action through help-seeking; this sentiment was also shared by participants in the current study. Not only can socially acceptable masculine ideals such as leadership be celebrated, but they can also be woven into health education programs that encourage depressed men to cultivate healthy relationships with their women partners, families and health care providers.

National media campaigns to spread depression awareness in a very public way can help to lower societal stigma regarding men’s depression and open dialogues of understanding. Initiatives such as “R U OK? day in Australia and “Let’s Talk Day” here in Canada can help to improve public awareness of depression in men and mental health
issues in general (Martin, 2012; Wilhelm, 2009). The participants in the current study and other research findings have identified the important role of celebrity public disclosures of men’s depression in creating greater public acceptance (McCusker & Galupo, 2011).

As the findings of the current study illustrate, men are unlikely to seek help for depression so health services that allow men to engage in self-help activities might be particularly useful. Wilhelm (2009) suggested that depressed men do well with depression-related health services that are goal oriented and focus on doing activities to complete steps toward recovery. An example of this concept is an initiative like the “Men’s Depression: Help Yourself” website through the University of British Columbia. Public health promotion campaigns for services like this could be launched on university campuses, public transportation, community centres, physician offices, sporting venues and other places where men gather (McCusker & Galupo, 2011). Ryan et al. (2010) noted that up to 60% of students stated that they would engage in internet-based, self-help activities and several participants in the current study confirmed this finding stating they have used the internet in some capacity to help manage depression. Such awareness campaigns must focus on language that appeals to hegemonic masculine ideals like strength and leadership (Noone & Stephens, 2008; Wilhelm, 2009) and would further benefit from celebrities disclosing their struggles with depression (McCusker & Galupo, 2011).

Health care providers can normalize asking male clients how they feel (emotionally) at every office visit or community contact; the men in the current study stated that keeping an honest and open dialogue is critical to successful care. Health care providers should not settle for “stressed” as a description of how a male client is feeling and they should be vigilant in watching for overt emphasis on somatic complaints.
described by men that might be indicative of depression. Opportunities exist to delve deeper into what “stressed” means through asking more probing questions possibly including:

- *What do you mean by that?*
- *How are you sleeping?*
- *How are you coping?*
- *Can you describe any physical symptoms?*
- *What do you do to relieve “stress”?*
- *Who is in your support network?*
- *Do you confide in anyone about your problems?*

As the participants in the current study, and other researchers have suggested, perceived support from their women partners is crucial to their management of men’s depression (Johnson et al., 2012; Oliffe et al., 2011). Public awareness campaigns that target and educate women on how to help depressed men are critical. Further investigation into how gender relations affect depression is imperative as the findings from this study demonstrate the critical role women play in helping depressed men manage their daily lives.

Health care dollars are clearly best utilized for program development that meets the needs of the population while offering enough options to appeal to people with different cultural backgrounds (Pilgrim & Carey, 2012). Another avenue for future research into depressed men’s help-seeking might focus on how ethnicity and culture interact with masculinity in affecting choices regarding help-seeking and effectiveness of therapies offered.

Continued public health funding is critical to maintain and improve services for
community outreach teams for vulnerable populations in areas such as Vancouver’s Downtown Eastside (DTES) to reach unemployed, housing and food insecure people with histories of trauma and addictions issues. Several participants in the current research disclosed that they were members of this population. In a study about connecting with vulnerable youth regarding mental illness, Dixon, Funston, Ryan and Wilhelm (2011) found it was useful to ask what worked for those who have had treatment in the past and to ask why many had never chosen to seek help.

Finally, while the current research did not focus on the effects of men’s depression on children, policy changes to include men as clients in perinatal care for childbearing families is a great (and currently missed) opportunity in British Columbia to catch and refer depressed men to appropriate resources through screening and public health nursing contact. In this regard, public health nurses can play a critical role in creating awareness about men’s depression and offer men information about depression-related health services. This can be achieved, in part, through in-home contact that efficiently brings resources to the doorsteps of men in challenging and stressful new life roles. For many men, taking part in perinatal care with their women partners may be a re-entering into the health care system after years of disengagement as healthy, young men and this can provide a great opportunity for health care providers to re-engage men with their health. Chin, Daiches and Hall (2011) noted that men are highly likely to participate in perinatal health care with their partners making this a prime opportunity to spread awareness of men’s depression and depression-related health services.

In light of the findings of the current study, avenues for future qualitative research might also include: 1) gaining greater insight into women’s perceptions of the roles they play in supporting their depressed partners 2) further exploring the dichotomy between
what depressed men recommend to others and what they choose to do for themselves in relation to help-seeking and 3) examining why depressed men would choose to withhold details about their experience from their women partners if they indeed act in such critical caretaking roles.
References


Oliffe, J., Kelly, M., Bottorff, J., Johnson, J. & Wong, S. (2011). "He’s more typically female because he’s not afraid to cry": Connecting heterosexual gender relations and men’s depression. *Social Science & Medicine, 73*, 775-782.


