A GROUP PSYCHOTHERAPY PROGRAM FOR YOUNG MEN WITH DEPRESSION

by

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Abstract

It is estimated that 60% of people who die by suicide experience depression. For young people aged 15 to 34, suicide was the second leading cause of death in 2012. Men have had higher rates of suicide in Canada at every point in time – up to 3 times higher depending on the year - for the past 60 years. This qualitative study explores the experiences of ten male adults between the ages of 18 to 32 with mild-to-moderate symptoms of depression that participated in a single-gender group psychotherapy program called, The Men's Transition Program (MTP). This study investigated the interventions and processes that were reported as helpful, in what capacity they were, and the perceived impact of these during and after the program. Ten semi-structured in-depth interviews, with questions inspired by the Enhanced Critical Incident Technique, were conducted. Thematic analysis was utilized to examine the reported changes as a result of the processes and interventions implemented in the program. Themes that emerged included: social connection and support, interpersonal learning, positive mood, self-confidence, self-esteem, normalization, improved social functioning, reduction in guilt, higher energy levels, and increased motivation. Implications of these findings will be discussed.

Preface

This thesis is an original and unpublished work by the author, Alistair Gordon. However, ethical approval was obtained by the University of British Columbia Behavioural Research Ethics Board on January 14, 2014 (H13-03165) under Project 4 of the Men's Depression and Suicide (MD&S) Network (sponsored by Movember Canada). The author of this work utilized data that he collected as part of his employment in the Men's Depression and Suicide Network at UBC. As such, archival data is being utilized in this independent study.

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Chapter 1: Introduction

According to Statistics Canada (Navaneelan, 2012), mental illness is the primary risk factor of suicide, as 90% of persons who struggle with suicide experience mental health challenges (Barzlay & Apter, 2014). Men have had higher rates of suicide in Canada at every point in time – up to 3 times higher depending on the year - for the past 60 years (Navaneelan, 2012). And, it is estimated that 60% of people who die by suicide experience depression. However, no *one* factor is the sole catalyst of suicide. The cause of suicide is usually *multifactorial*, such as from depression (or other mental illness), deterioration of intimate relationships, career or financial difficulties, declining physical health, a significant loss of some kind, or a deficit in relational support.

For young people aged 15 to 34, suicide was the second leading cause of death in 2012 (Navaneelan, 2012). Although severe depression is consistently associated with risk of suicide, clients with minor depression and dysthymia are under-represented, as long-term dysthymia is a strong predictor of a greater severity of depression and the ongoing risk of suicide (Barzilay & Apter, 2014).

This qualitative study explores the experiences of young adult men between the ages of 18 to 32 with mild-to-moderate depressive symptoms who participated in an all-male group psychotherapy program called, The Men's Transition Program (MTP). The MTP is part of the Men's Depression & Suicide Network at the University of British Columbia and generously sponsored by Movember Canada. This program was adapted from the Veteran's Transition Program because of its reported helpfulness and receptivity to men who have participated in it (Westwood, McLean, Cave, Borgen, & Slakov, 2010).

The MTP was piloted for three reasons. One, because of the high suicide rates of men compared with their lower reported rates of depression (Navaneelan, 2012). Two, the challenge in attracting men to therapy to seek help for their depression (Johnson & Oliffe, 2012). And three, because of the value of an all-male group counselling setting, as it has been found to mediate social isolation, which is a significant risk factor of depression and suicide (Good & Brooks, 2005).

The kind of knowledge and understanding that is expected to be generated from investigating this topic includes: (a) aspects of the program that were reported as being helpful, unhelpful, and what the participants would have liked as part of the program, (b) how and why the aspects were helpful, unhelpful, or desired, (c) changes that took place as a result of the various aspects or general nature of the program, and (d) how these reports compare with current literature and the potential implications of the participants' reports.

1.1 Depression

According to the APA (2013), depression is characterized by symptoms of low mood and a loss of interest or pleasure in activities for a period of 2 weeks or more. Associated symptoms often include changes in appetite, sleep, physical activity, and energy levels; low self-esteem or guilt; lack of clear thinking, difficulty in concentrating or decision-making; and, suicidal ideation. The most frequent symptoms of depression have traditionally comprised of feelings of sadness, worthlessness, and excessive guilt.

Nonetheless, studies (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Cavanagh, Wilson, Kavanagh, & Caputi, 2013; Chuick, Greenfeld, Greenberg, Shepard, Cochran, & Haley, 2009) have posited that the way men express their symptoms of depression may

differ from women – potentially because of dominant socio-cultural norms to avoid the shame of deviating from these norms – and this may translate into expressing their symptoms of depression through anger, an increase in interpersonal conflicts, social withdrawal, and addiction (including excessive working).

To illustrate this, Brownhill et al.,'s (2005) qualitative study examined how men experience depression. Participants in this study consisted of 77 male teachers (n=27) with an average age of 48.4 years and male students (n=50) with an average age of 20.4 years from four educational institutions. Female participants comprised of twenty-five teachers (n=15) with an average age of 46.1 years and students (n=10) with an average age of 37.6 years. The results of this study suggest that some men who have depression can express it through symptoms of avoidant behaviour that may result in aggressive and suicidal tendencies. In addition, differences in gender relate to the expression - not the experience - of symptoms of depression. The authors propose that this avoidant disposition is potentially from restrictive norms about what a man should ideally be. One potential caveat of this study is with regard to the finding that men do not experience depression differently despite varying in the expression of it. The subjective experience may differ because shame about feeling sad or weak, which many men have been found to perceive, may result in denial of their sadness, thus changing the subjective experience of depression. Notwithstanding, at a physiological level sadness may still be experienced by the organism in primary process emotional affect (Panksepp & Biven, 2012). Thus, sadness may only be *consciously* denied or suppressed.

Another illustration involves a meta-analysis conducted by Cavanagh et al., (2013) that summarized what is known about how men express their symptoms of depression

and to assess whether diagnostic criteria for identifying male-type depression is accurate. This review involved 15,966 studies that were analyzed for relevance. 30 studies were selected that met the criteria to include in their review. The findings suggest that there is a difference between how men and women express symptoms of depression. Specifically, men were reported to express symptoms of depression in the form of social isolation and unhealthy coping strategies. One potential limitation of this study is that gender and sex do not seem to be distinguished. This is significant because some men (gender) may not identify as male (sex). Nevertheless, a strength of this study is the comprehensive assessment of the present knowledge on this topic, which provides an up-to-date examination that accounts for any changes in cultural attitudes that have shifted, which more historic studies may lack.

1.2 Social Isolation, Men, and Depression

One of the features of depression in men is social isolation. Hernandez, Han, Oliffe, & Ogrodniczuk (2014) conducted a qualitative study examining men's self-reported experiences in seeking help for depression. The participants included thirteen previously diagnosed or presently treated men with depression. The vast majority of participants were single, heterosexual Caucasians, who were employed, with a high level of education, and all lived in Vancouver, British Columbia. Semi-structured interviews that were 60 to 90 minutes in duration were conducted. The findings reveal that while symptoms of depression that men identified aligned with diagnostic criteria, the expression of depression differed, and included social isolation, anger/irritability, and 'binge-type behaviour'.

This tendency for men to socially isolate is a significant factor in depressive

episodes. A case study by Cochran & Rabinowitz (1996) looked at the in-depth experiences of a 42-year old client who was a medical physician that struggled with depression. This illustration revealed significant and long-standing "experiences of isolation, shame, sadness, and loneliness [that] never really went away" (p. 599). Two potential limitations of this case illustration involve the lack of generalizability because it is a single case. And, because this study took place 20 years ago in 1996, so socio-cultural constructions of gender norms that influence the expression of depression in men might change over time. Although, one strength of this case study is the fact that it looks at in-depth, real-life experiences which corroborate with clinical writings related to similar reports of men (Good & Brooks, 2005).

Social isolation is a particularly worrisome expression of depression because social isolation is a risk factor for suicide. Oliffe, Ogrodniczuk, Gordon, Creighton, Kelly, Black, & Mackenzie's (2016) quantitative study investigated stigma in the views of men and women in Canada about male depression and suicide. Two groups were investigated. The first group (n=541) involved Canadians who had no personal experience with depression. The second group (n=361) were Canadians who had personal experience with depression. Three surveys were administered to the respondents and measured the stigma of depression, the stigma of suicide, and self-stigma of depression. The results revealed that 60% of respondents indicated that they believed men who died by suicide were isolated. One of the limitations of this study is that the answers on the survey were 'forced-choice', so there may be a gap in the real-life experiences of the respondents that illuminate the context-specific nature of these findings. Strengths of this study include that it is the *first* national survey comparing men and women's stigmas of

depression regarding male depression. And second, that it fills a gap in the literature regarding quantitative data that previously was lacking.

Isolation and poor social support have even been found to be predictors of depression. Hagerty & Williams (1999) investigated the impact that loneliness and various forms of social support had on depression. 150 clients who experienced Major Depressive Disorder participated. Questionnaires were administered and the results suggest that emotional social support (i.e., belonging) mediated symptoms of depression.

As it relates to men, this finding is supported by Knox, Vail-Smith, & Zusman (2007) who suggest that men tend to feel lonelier, and do not have as much emotional support and intimacy compared with women. This is asserted to be because men do not frequently bond in any depth with other men and instead rely on their romantic lives for substantial connection (O'Neil, 2008).

1.3 Social Support and Connection

'Social support' and 'social connection' are specified as being distinct in the literature by some researchers, and others use these terms interchangeably. For example, Hagerty & Williams (1999) characterize 'social support' as including connection, whereas Williams & Galliher (2006) specify connection and support as separate constructs.

Social support. Cohen (2004) outlines the construct of social support and defines it as providing psychological or physical resources in order to assist another. Social support can be categorized into three types: emotional, informational, and instrumental. Emotional support refers to receiving empathy, caring, and trust, and opportunities for expressing emotions. Instrumental support pertains to providing material assistance, such

as money or physical help. Informational support relates to providing information, such as advice.

The effects of social support on depression have been shown in Sayal, Checkley, Rees, Jacobs, Harris, Papadopoulos, & Poon's (2002) study that investigated 23 in-patients experiencing depression. Participants were assessed both in the ward and at home. Levels of social support, ratings of depression, and cortisol levels were analyzed. The findings suggest that symptoms of depression *decrease* as a result of *greater* social support. Limitations of this study include the small sample size and the fact that all of the participants were in-patients. Thus, future studies that examine outpatients may help to provide greater insight into whether symptoms of depression decrease for outpatients given the potential opportunity for greater support from family and friends.

Social connection. Lee, Draper, & Lee (2001) delineate two categories of social connection: closeness and belongingness. Closeness relates to feeling understood, perceiving emotional affection and stability in the emotional bond with the respective other, and a sense of similarity in virtue and mores. Belongingness pertains to a sense of group inclusion and partnership. 'Social support' differs from 'social connection' in that support is characterized by advocacy and connection by intimacy. For example, in support, there is primarily an implicit intention to help, whereas, inconnection, there is an implicit intention to bond.

Williams & Galliher (2006) investigated the impact of social support and social connection on men and women who experienced depression. Participants included 272 college students that included 179 were females and 93 males, in which 90.4% were Caucasian. Questionnaires were administered, and the duration of completing these was

30 to 45 minutes. Several of the measures in this study included: the Quality of Relationships Inventory (QRI) (Pierce, 1994, Sarason, & Sarason, 1991) that measures support; the Social Connectedness Scale-Revised (SCS-R; Lee et al., 2001), which assesses experiences and difficulties in emotionally connecting with others; and, the Center for Epidemiology Studies-Depression Scale (CES-D; Radloff, 1977), that measures symptoms of depression in 'nonpsychiatric populations'.

The results of this study suggest that social connection is the active ingredient in the construct of social support. For instance, support and social skills training were found to only reduce symptoms of depression *if* this fostered social connection. This is congruent with clinical writings by Yalom (2005), who proposed that cohesion (i.e., connection) is the medium by which all other therapeutic benefits occur. That is, cohesion in the group is necessary for participants to attain normalization, interpersonal learning, social learning, etc.

1.4 Group Psychotherapy

Group psychotherapy is characterized by a small number of participants (e.g., 8 to 10) and facilitators who share a therapeutic space where group rules commonly include respect, confidentiality, constructive feedback, and turn-taking that help to foster an atmosphere of trust, safety, and openness to promote connection, support, normalization, and exploration. Burlingame, Fuhriman, & Mosier (2003) outline groups that range anywhere from support groups and psycho-educational groups to treatment groups, which address such diagnoses as depression, anxiety, and addiction. Common treatment modalities include integrative, psychodynamic, and cognitive-behavioural approaches.

Several meta-analytic reviews have been conducted examining the effectiveness of group psychotherapy (Burlingame, Fuhriman, & Mosier, 2003; McRoberts, Burlingame, & Hoag's, 1998). Burlingame, Fuhriman, & Mosier (2003) conducted a meta-analytic review of 111 experimental and quasi-experimental studies over a 20-year period to illuminate the 'differential effectiveness' of group psychotherapy. This means that the type of group treatment varied by its structure in the proposed processes of change. These are classified into four types. For example, one type is a focus on the therapist or manual being the 'guiding force' where members respond to the direction of the therapists' lead of the topic or content. Another example is the participants in the group who interactively discuss and structure the treatment in a present-focused manner.

The types of variables that were reviewed were the primary diagnosis (e.g., depression), theoretical orientation (e.g., multidisciplinary), setting (e.g., university counselling service), and therapists' degree. The results showed that clients who received group treatment "were better off than 72% of the untreated controls" (p. 3), and improvement was associated with the setting, diagnosis, and composition of the group.

Further evidence supporting group psychotherapy as a viable treatment modality can be shown in McRoberts, Burlingame, & Hoag's (1998) study which examined the *comparative* efficacy of individual and group psychotherapy. Their analysis consisted of 23 outcome studies that compared both individual and group treatments in each study. The results revealed that there was no difference in outcome between the group and individual formats. A limitation of this study that the authors report is that dissertations that were unpublished were not utilized, which could have potentially provided a source for a greater weight of evidence in either direction.

The effectiveness of group therapy is submitted by Yalom (2005) to be a result of 11 therapeutic factors. Some of these factors include: social connection (i.e., cohesion), normalization (i.e., universality), social support (i.e., guidance via information being imparted), understanding oneself through relating with others (i.e., interpersonal learning), internalizing adaptive attitudes and behaviours of group members (i.e., modeling), and release of tension via emotional expression (i.e., catharsis).

1.5 Men, Gender-Role Socialization, and Help-Seeking

Many studies have found that certain masculine ideals, which some men hold, can influence whether they seek help for their health-related concerns (Chuick et al., 2009; Emslie, Ridge, Ziebland, and Hunt, 2006; Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012; Shepard, 2002). This is termed as 'male gender role conflict', which can be defined as the "constriction of potentials and expression of human needs (e.g., tender or vulnerable feelings) out of a fear of feeling or behaving in any way feminine" (Shepard, p. 3, 2002). Such masculine ideals pertain to being independent and having emotional control (Barbee, Cunningham, Winstead, Derlega, Gulley, Yankeelov, & Druen, 1993). This is postulated to occur through gender role socialization. Gender-role socialization can be characterized as "learning attitudes and behaviours from cultural values, norms, and ideologies about what it means to be men and women" (Addis & Mahalik, p. 7, 2003). As these authors also point out, it is important to note that not all men ascribe to traditional masculine norms, and even those who do can vary individually in the degree and context to which they identify with such ideologies.

Nevertheless, many men have been found to be reticent to seek help due to the stigma associated with depression. Oliffe et al.,'s (2016) Canadian national survey study

investigated hundreds of men and women with both direct experience with depression and no personal experience with depression. This study revealed that both men and women with direct personal experience had stigmatizing views about depression to an approximately equal degree, yet; a greater number of men were found to feel embarrassed about *seeking help* for depression. This finding suggests that men might tend not to seek help because of embarrassment and shame for having depression, and could support past research and clinical writings pertaining to gendered norms playing a factor in the reticence for many men to attain assistance with their mental health challenges.

This does not mean that men do not have a *desire* to attain help, but instead, it may indicate reticence to *engage* in seeking help due to feelings of shame around appearing weak and vulnerable. This desire to seek help can be shown in Emslie et al.,'s (2006) qualitative study that investigated the experiences of men with depression through 16 interviews that explored the relationship between gender identity and depression. These authors defined dominant masculine norms as being marked by "emotional control and lack of vulnerability" (p. 2246). The results showed that a significant aspect of recovering from depression was re-conceptualizing their notions of masculinity to alternative narratives such as being responsible to others, being 'one of the boys', and regaining control. Another finding was the importance of seeking out other men who also value talking and connecting at a deep level about personal experiences with depression, and this may assist in normalizing their experiences, which may foster help-seeking tendencies.

This study also suggests that men who are depressed are not *unwilling* to speak about their issues; rather, it suggests that many men *are* willing if it were not for fear of

being shamed from appearing weak. And, men seem to have a desire to connect with like-minded men in order to transform or reframe their conceptions of masculinity into more adaptive perspectives. The authors also recommend clinicians who are working with men to take a positive approach that focuses on responsibility, strength, and self-control.

Tang, Oliffe, Galdas, Phinney, & Han's (2014) study, which examined help-seeking among college-aged men, suggests that gender can indeed be relationally co-constructed either in adaptive or limiting ways. From a limiting perspective, this can lead to men's desire to appear 'depression-free', and in turn, result in the avoidance or masking of their attempts to seek out or engage in help for their depression. In adaptive ways, the reconceptualization of traditional masculine norms can occur, and this was found to primarily take place through male-to-male interactions or with family members. This finding is important because it provides hope and potential strategies (i.e., male-to-male, or family member interactions) for the possibility of transforming socialized norms to improve help-seeking behaviour in men. This finding is congruent in other studies in that it has been found that an essential aspect of men's recovery from depression is the reconceptualization of their masculinity (Emslie et al., 2006).

1.6 Gender and Psychotherapy

According to Galley & Colvin (2013), *gender* is a socio-cultural creation that informs the attitudes and behaviour of an individual. *Sex* refers to biological and genetic constituents (i.e., chromosomes, hormonal profiles, and internal and external sex organs). Male, female, or intersex refers to sex; and, masculine and feminine (or a combination therein) pertain to gender. Due to gender being influenced by social and cultural

variables, it can vary in some breadth depending on the particular norms of the culture or sub-culture. This variability due to culture has implications on virtually every aspect of life that involves social experience – including gendered norms that influence help-seeking behavior and preferences for therapy.

There is a gap in the literature regarding whether group or individual psychotherapy is preferred by men, or has greater effectiveness for male clients. The literature that has been conducted suggests that men can benefit from both individual and group psychotherapy; although, group therapy has been hypothesized to be a particularly helpful treatment format for men (Ogrodniczuk & Oliffe, 2009).

Even so, quantitative research suggests that men find both formats equally helpful. For example, Dwight-Johnson, Sherbourne, Liao & Wells' (2000) study involving 1187 male and female patients with depressive symptoms revealed that approximately an equal number (53% vs 47%, respectively) preferred individual and group counselling. The authors of this study conceded that a client's preference depends on various life circumstances at different stages of life. That is, it depends on factors such as demographics (e.g., age or gender identity), the type of personal challenge (e.g., death or relationship difficulties), the degree to which the client has explored their issue, how sensitive or intimate the particular issue is to a client, their level of comfort in sharing it, and also personality factors and cultural factors such as the degree to which they ascribe to collectivistic and individualistic cultural values.

Another quantitative study shows that men might prefer individual therapy. Hernaandez, Oliffe, Joyce, Sochting, & Ogrodniczuk's (2014) study examined the types of treatment that male outpatient psychiatric patients preferred, and how willing they

were to partake in psychotherapy. Three studies were conducted under the umbrella of Hernaandez et al.,'s (2014) article that consisted of a total of 170 men and 227 women who were assessed using several different self-report measures for psychiatric symptomatology and preference of treatment. In one of the studies, a greater number of men reported that they preferred individual therapy to group therapy, in comparison with results associated with female outpatients' preferences. Due to the quantitative nature of the previously noted study and that answers on the measures were 'force-choice', future *qualitative* research may help to fill this gap in the literature.

1.7 Single-Gender Group Psychotherapy

Group therapy sometimes involves all-female or all-male participants. These are termed as single-gender groups. Single-gender group therapy can be defined as a homogeneous group of individuals sharing a common gender identity who engage in group psychotherapy together. Single-gender group therapy – as compared with mixed-gender group therapy – is suggested to provide the opportunity for participants to explore and discuss gender-specific concerns associated with the respective presenting problem in a setting that is emotionally safe (Greenfield, Cummings, Wigderson, & Koro-Ljungberg, 2013).

There are numerous *clinical* writings that advocate men's preference for, and the helpfulness of, group therapy and an all-male therapeutic setting (Andronico, 1996; Kiselica & Englar-Carlson, 2010; MacNab, 1990; Ogrodniczuk, 2006; Powell, 2006). For example, Powell (2006) recommends an all-male group setting so as to prevent distraction and a divide in experiences as a result of gender differences. This is congruent with MacNab's (1990) proposition that men might only find mixed-gender groups helpful

if they are not a minority in number because they otherwise may feel isolated, vulnerable, and not able to be fully present to meaningfully engage with other members.

Other clinical writings suggest that men's groups create an atmosphere of trust, that fosters support, and, in turn, reduces social isolation (Andronico, 1996). All-male groups have also been shown to promote a safe space for men to be vulnerable and learn that other men have similar challenges or fears (i.e., normalization), which decreases social and emotional isolation by offering interpersonal and emotional connection (Ogrodniczuk & Oliffe, 2009). In addition, all-male groups may be beneficial because these might assist men in feeling more secure in appearing vulnerable, as men may otherwise be preoccupied with being perceived as in high regard with women in a mixed-gender group setting (Delucia-Waack, Kalodner, & Riva, 2013; Jolliff, & Horne, 1996). Such security in appearing vulnerable may aid in transforming masculine norms that mask and distract from confronting the experience and expression of depression so that engagement in treatment can occur.

These clinical writings are congruent with some qualitative research in the literature. For example, Ogrodniczuk's (2006) article reviewed two studies of depressed male and female patients participating in mixed-gender group therapy. These findings suggest that men may not benefit from mixed-gender groups, and instead are more open to an all-male group counselling setting versus a mixed gender setting.

A potential preference for single-gender group therapy may not be unique to men as many women appear to favour it. For example, Greenfield et al., (2013) conducted qualitative interviews using grounded theory analysis for 36 women who participated in single-gender and mixed-gender group therapy for substance abuse. The results showed

that in the single-gender group, women "more frequently endorsed feeling safe, embracing all aspects of one's self, having their needs met, feeling intimacy, empathy, and honesty" (p. 750). The cohesiveness and support among the participants in the single-gender group were also reported to enable women to concentrate on gender-specific topics that helped to support their recovery from substance abuse.

Another finding of this study was that women experienced sexual tension and an atmosphere devoid of empathy in mixed-gender group therapy, and that mixed-gender formats can minimize the needs of women suggesting that single-gender groups may foster greater openness and disclosure of women. This may be because some of the female participants could relate better with other female participants as they were able to address and discuss gender-specific repercussions that the presenting problems had on their lives. Studies have found that mixed-gender settings can result in women feeling like a minority and prevent emotional disclosure. Additional research has suggested that mixed-gender settings can have the same impact on men (MacNab, 1990) as they do on women (Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996) if men are a minority number in the group.

Despite there being numerous *clinical* writings (Andronico, 1996; Kiselica & Englar-Carlson, 2010; MacNab, 1990; Ogrodniczuk, 2006; Powell, 2006) and some qualitative research previously mentioned supporting men’s preference for, and the helpfulness of, group therapy and an all-male therapeutic setting, there is still quite a large gap in the *research* literature that clearly demonstrates this (Ogrodniczuk & Oliffe, 2009).

1.8 Therapeutic Enactment

Therapeutic Enactment is a group-based intervention that is theorized to change implicit memory through simulating lived experience of a past traumatic memory in a more adaptive manner that provides the relational support and cognitive strategies that may have been lacking during the initial traumatic experience (Westwood, Langley, & Gordon, 2015). TE's theoretical underpinnings consist of Gestalt, Narrative, Schema, and Object Relations (Westwood, Keats, & Wilensky, 2003). Although TE was inspired by classical psychodrama (Moreno, 1987), the two approaches are markedly distinct from one another (Black, 2003). The distinction rests in the greater degree of structure and planning of TE so as to increase safety and decrease spontaneity of potentially hazardous experiences during trauma repair. Another distinction is the attention to fostering the therapeutic relationship between the client and the therapist *and* group, whereas Psychodrama has an individual focus on the protagonist. A third distinction is that catharsis is a means of understanding and grieving the loss associated with the trauma as a precursor to repair. This is in contrast with Psychodrama's conception of catharsis as the primary constituent of therapeutic change.

TE's generally comprise of 10 to 20 people over a 2 to 3 hour time period. Westwood and Ewasiw's (2011) article delineate five phases of TE: Assessment and Preparation, Group Building, Enactment, Sharing and Closure, and Integration and Transfer. The first phase involves an individual interview to assess and identify one to three key events or those that best represent the identified schema that is hypothesized to be a core factor of the respective symptoms of the client. The second phase takes place within the group and includes interpersonal sharing and trust building. The third phase

pertains to enacting the structured scene(s) in the group in a systematic manner to ensure the safety of the client during trauma repair. Most or all of the group members are involved as participants who take on roles in the client's scene(s). The fourth phase is with regard to sharing insights, observations and experiences both personally and as the role in the scene(s), in addition to reviewing the goals completed and summary of progress made, group closure, and fostering normalization of all the members' experiences. The fifth phase includes a follow-up and the identification of resources and strategies for reconnecting with the community.

Research conducted on TE has found that this intervention enhances self-beliefs, relationships, self-confidence, self-esteem, and meaning in life (Baum, 1994; Black, 2003; Brooks, 1998; Brown-Shaw et al., 1999; Hirakata & Buchanan-Arvay, 2005; Keats, 2000; Morley, 2000). TE has also been shown to correlate with a decrease in symptoms of depression. One illustration of this is Cox, Westwood, Hoover, Chan, Kivari, Dadson, & Zumbo's (2014) study that investigated military veterans' experiences in a group treatment program that featured Therapeutic Enactment as a primary intervention. There were 56 male participants in total in this study all of whom participated throughout the entirety of the program – there were zero dropouts. Two measures were utilized in this study with a pre-to-post test research design. These measures included: The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), and The Trauma Symptom inventory (TSI; Brier, 1995). The results suggest that from the many symptoms that were investigated, depression decreased the most, both statistically and clinically.

1.9 Active Engagement

Active engagement refers to an experiential learning delivery format where participants are engaged in a relevant activity that may include an interpersonal discussion to which they experientially and procedurally learn and explore the target knowledge, skill, or new experience in the present moment. In other words, Active Engagement involves 'being' and 'doing' in the present moment, as opposed to solely abstract and conceptual thinking (Amundson, 2009). Active Engagement is thought to produce embodied learning. Embodied learning can be defined as the psychological assimilation of concepts, objects, or events that form implicit and explicit representations in memory through perceptual, somatosensory, and motoric experiences (Kontra, Goldin-Meadow, & Beilock, 2012; Niedenthal, 2007). This is in contrast to traditional learning methods that involve the speaker or teacher presenting to a passive audience with little or no engagement on the part of the audience.

1.10 Action-Based Interventions

This is similar to Active Engagement but specifically relates to the type of interventions that men with high gender role conflict may be more receptive to (Caldwell & Peplau, 1982; Good & Brooks, 2005; Kiselica & Englar-Carlson, 2010). Action-based interventions are characterized as activities that share a common goal, and may accompany interpersonal sharing and emotional disclosure during the activity. Examples include such activities as role-playing, storytelling, gestalt techniques (e.g., empty chair), metaphor work, and early recollections. For instance, Englar-Carlson & Kiselica's (2013) suggest strategies for assisting male clients that harness the tendency for men to often develop friendships through activities where there is a common goal. And, that

mental health professionals can utilize this tendency in a group therapy setting by implementing activities with shared goals.

Jolliff & Horne (1996) found that group activities might be useful for any gender or treatment group, but activities such as role-playing and empty-chair are especially well-received by men in groups because emotional exploration and disclosure are achieved in an indirect manner, rather than being the primary foci. Additional research (Good & Brooks, 2005) regarding whether men prefer such activity-based interventions versus an interpersonal sharing focus also suggests that men tend to prefer therapeutic groups that are action-based (e.g., role-playing) instead of groups that are only conversational in nature because male interactions are frequently based around an activity instead of primarily interpersonal sharing.

1.11 The Present Study

The current study assesses what men report as helpful, unhelpful, and what they would have liked in the program for reducing their symptoms of mild-to-moderate depression in the single-gender group therapy program called the Men's Transition Program (MTP). The MTP is for young men aged 18 to 32. The program spans two, three-day weekends, was piloted because studies suggest that men might not seek help for depression as often as women (Chuick et al., 2009; Emslie, Ridge, Ziebland, & Hunt, 2006; Shepard, 2002), prefer group counselling to an one-on-one counselling, (Ogrodniczuk & Oliffe, 2009) and an all-male setting to a mixed-gender setting (Andronico, 1996; Kiselica & Englar-Carlson, 2013; MacNab, 1990; Ogrodniczuk, 2006; Powell, 2006).

The assessment of the impact of the program addressed the following: processes, interventions, and changes. Processes refer to ‘how’ the program was implemented. Interventions pertain to ‘what’ was implemented. Changes relate to the reported impact that the processes and interventions had on the participants. The processes of the program included: a group setting, all-male participants, Active Engagement, and traditional learning (i.e., presentations). The interventions consisted of communication skills training, a guided autobiography, Therapeutic Enactment, an emotional awareness presentation and activity, and a cognitive distortions presentation and activity.

The assessment of interventions in the MTP is technically a feature of program evaluation, nevertheless; it has been incorporated into this study in order to gain insight into the subjective experiences of the participants about what was helpful, and the impact that the program had on their lives during and after the program. Thus, the program evaluation feature of this study is important to the research question because such an assessment is intended to help reveal the type of interventions that the participants reported as contributing to the potential changes in their lives as revealed in the themes.

In summary, this study explores (a) aspects of the program were reported as being helpful, unhelpful, and missing (wish list), (b) life changes that took place during and after the program, (c) themes and patterns of the participants’ experiences, and (d) connects the results with existing theories in the literature.

This study is expected to inspire future interventions for men’s depression and suicide, and to assist in understanding the experiences of men so as to (a) inspire future quantitative research to test the effectiveness of treatments for men with depression and what might attract men to therapy, and (b) support or contest existing theories regarding

the effectiveness of treatment settings, delivery formats, and interventions for men with depression.

Chapter 2: Method

This study is interpreted through a synthesis of realist, constructivist, and constructionist paradigms. Lived experience consists of an integration of physical reality (i.e., realist/essentialist), psychological constructs of reality (i.e., constructivist), social constructs of reality (i.e., constructionist). The only variance in interpretation is at the level of processing, but all take place simultaneously. For example, there is a set physical reality that we interpret through sensory and psychological processes, which we consciously and unconsciously interpret as accurately or adaptively as possible, but because social bonds require synchrony of values and beliefs to maintain those bonds, we also see reality through those values and beliefs. And all of these influence our perceptions of 'reality'.

The design that will be utilized is thematic analysis (TA) (Braun & Clarke, 2006), with interview questions that were inspired by the Enhanced Critical incident Technique (ECIT) (Butterfield, Maglio, Borgen, & Amundson, 2009). TA is a foundational method in qualitative research. It is used to identify the meanings of themes, which is "one of the few shared generic skills across qualitative analysis" (Braun & Clarke, 2006). TA is reported to have the capacity to be employed from essentialist and constructionist world paradigms and is a flexible research tool that is capable of providing rich and elaborate accounts of data. For these reasons, a thematic analysis is expected to be the ideal tool for this research study in order to determine the perspectives and significance of the reported helpfulness of various settings, activities, and changes of the MTP.

Braun & Clarke (2006) categorize thematic analysis into six phases. The first phase involves transcribing, reading, and taking initial notes of the data. The second

phase requires coding features across the data set. The third phase relates to forming themes from the codes. The fourth phase pertains to conducting a review of the themes to ensure the raw data matches the themes to the best of the examiner's interpretation. Phase five necessitates an analysis of the big picture of the themes and generation of labels and definitions of the themes. The sixth phase is with regard to extracting quotes from the data that best represent each of the themes, research question(s), and literature.

The ECIT (Butterfield et al., 2009) was also utilized in so far as to guide the content of some of the interview questions because ECIT is amicable for exploratory research that seeks rich first-hand perspectives regarding the significance of settings, activities, and changes that take place in subjective experience.

2.1 Participants

Participants included ten university-aged men between the ages of 18-32 (N = 10). All of the participants are Canadian citizens. Seven of the ten participants were students in college or university. The ethnicity of the participants included: 6 Caucasians, 1 Vietnamese-Canadian, 1 Guatemalan-Canadian, 1 Mauritian-Canadian, and one of unspecified ethnicity. Participants were referred by counselling services from various universities and two private organizations across the lower mainland of British Columbia. The criteria for referral included mild to moderate depression, as identified by informal assessment and clinical intuition of the referrer. This included attendance to DSM-5 criteria (APA, 2013), such as a decrease in positive mood, a loss of interest in daily activities, changes in appetite or sleep, fatigue, and lowered self-esteem and concentration. This also involved a felt sense of the client struggling that has become apparent within the therapeutic relationship. Data was collected at pre and post

intervention of the program, in addition to a 3-month follow-up.

2.2 Procedure

University students/program participants were referred from higher education counsellors who agreed to actively collaborate with the Men's Depression and Suicide Network. If a counsellor deemed that a client fit the MTP program, he/she was instructed to ask this individual if they are interested in participation in the MTP treatment and research initiative. Should the potential participant express interest, like more information, or would like to explore additional outside referral options, they were advised to contact the research director.

Interested participants were told that this therapeutic program is intrinsically linked to a research project and that participation requires engagement in an evaluation of the program's effectiveness. It was made clear that they are free to drop out at any time and that leaving the research component means leaving the program and vice versa. It was also explained that participation in the MTP is not linked to ongoing services with their counsellor or physician. That is, anything that occurs with the MTP occurs independently of other services and vice versa (i.e., the two do not affect each other).

In the event they wished to decline, they were provided with a list of alternative referral options for treatment. It was also explained that opting out would in NO way affect future opportunities for involvement with our program or related events. Should the individual be interested in participating, however, informed consent would be covered along with all related assessment details. Please find a sample dialogue below that was provided to recruiting counsellors: 10 participants (one group) who completed the MTP in June 2014 were contacted and interviewed 2 weeks after the completion of the

program. Two of the participants were interviewed over the phone. Eight participants were interviewed in-person. The interview was divided into three main categories - what was helpful, hindering, and wish list items, and concrete examples were drawn out. All of the interviews were audio recorded, and an auditory analysis was undertaken for each of the 10 participants.

2.3 Data Analysis

The data in this study were analyzed by coding the content, processes, and changes that the participants reported. Patterns and themes were then generated and categorized subsequent to coding. A semantic approach was utilized. According to Braun & Clarke (2006), thematic analysis typically involves either a semantic or interpretive approach. A semantic approach pertains to identifying the explicit meanings within the data. An interpretive approach is with regard to analyzing the latent themes - the implicit assumptions, ideas, and ideologies that are thought to be the foundation of the data.

Although, this study is not quantitative or mixed-methods in nature, The Male Role Norms Inventory - Revised (MRNI-R; Levant, Smalley, Aupont, House, Richmond, & Noronha, 2007) was utilized because of the potential for it to provide helpful insight into gender constructs as it relates to the impact that various aspects of the program may have had. The MRNI-R is composed of 53 items that measure ideology related to traditional masculine gender roles. This scale has seven sub-scales with an internal consistency ranging from .78 to .91 (Levant et al., 2007). A 7-point Likert scale (e.g., 1= Strongly Disagree to 7 = Strongly Agree) was utilized in which participants had the option of choosing their degree of disagreement or agreement about statements pertaining male gender role socialization.

2.4 Credibility/Trustworthiness Checks

According to Braun & Clarke (2006), thematic analysis does not involve "coding reliability checks" (Virginia Clarke, 2016, personal communication) because TA is "underpinned by the (realist) assumption that there is an accurate reality in the data that can be captured through coding. Our approach to TA sees coding as flexible and organic. With no one 'accurate' way to code data, the logic behind inter-rater reliability (and multi-independent coders) disappears" (Braun, 2016). Be that as it may, interview questions in this study were inspired by the ECIT, which does require reliability and other credibility checks. There is an additional reason why credibility checks have been implemented – regardless of the inclusion of the ECIT. This is because all qualitative research seems to need some manner of assurance that bias or lack of precision has not impacted the study (Amundson, 2016, personal communication). For this reason, and since my interview questions were inspired by the ECIT, a modified version of the ECIT's suggested credibility checks have utilized.

The first check involved asking an independent researcher to listen to one of the interviews to ensure that there was no undue bias that might affect the integrity of extracted data. According to this researcher, no bias was detected. The second check included requesting the same researcher to place 25% of the themes (that were chosen at random using an automated number generator) pertaining to the processes (e.g., group setting), interventions (e.g., TE), changes (e.g., social connection, interpersonal learning, etc.), and hindering and wish list items of the aforementioned examples into the categories of the themes. All of the items were placed in the correct themes, except for two themes. The first was with regard to social support because of its close association

with the construct of social connection. The literature on the distinction between the two constructs was reviewed and discussed, and agreement subsequently achieved. The second incongruity relates to the themes of normalization and a reduction in guilt. These two constructs were closely associated because a reduction in guilt often followed normalization. The sequence was analyzed and differentiation between the two clarified. Agreement was attained of this discrepancy.

The third check involved requesting an expert in the men's mental health field to read the results of this study to see if what they found made sense based on their clinical knowledge, experience, and research expertise in the field. This expert was queried about whether there were any noteworthy congruencies, surprises, or inconsistencies. They reported that the results came as no surprise that a group program reduced depressive symptoms. This is because understanding was achieved, aloneness was undone, and emotions achieved their appropriate action tendencies, which is exactly what clinical discourse predicts. And, while literature at times seems to downplay the effectiveness of interpersonal sharing with men, it more specifically refers to that which is packaged in a culturally inappropriate way. Given that this group was run by two ‘mentor/father’ like men who modelled the appropriateness of sharing feelings in a ‘male friendly’ way, the they see interpersonal sharing as fitting very well with both the scholarly discourse in the literature and their clinical observations. The context dependency (group vs. individual) also struck this expert as a predictable finding because each human is their own culture, which further complicates their needs as they arrive at each new moment of life. This finding was a reminder to them about the importance of protecting the truly client centered aspects of therapy and to avoid being so arrogant as to assume clinicians can

design approaches that fit social cultures that we have essentially invented (e.g., men are like this, women are like this, students are like this, etc.).

Chapter 3: Results

The results have been categorized into four sections. The first section pertains to the process-oriented results, which include: the setting (i.e., group vs individual counselling), gender homogeneity or heterogeneity (i.e., single-gender or mixed-gender), and teaching style (e.g., presentations or activities). The second section pertains to the content-oriented results, which are the interventions of the program, and these include communication skills training, a guided autobiography, Therapeutic Enactment, and training in identifying and mediating cognitive distortions. The third section reveals the reported impact (i.e., changes) of the processes and interventions of the program. And finally, the fourth section details the hindering and wish list themes that emerged. Each theme in its respective section is rank-ordered descending (highest to lowest) order according to the percentage of participants in the group who reported it, and then by the number of occurrences in which the theme emerged.

Regarding the extent to which participants ascribed to hegemonic masculinity according to the MRNI-R (Levant et al., 2007), the mean of the group prior to the program was 1.94. After the MTP, the mean was 1.36. Compared with Levant et al.,'s (2007) normative sample with an of $M = 3.14$, this suggests that many of the participants from the MTP ascribed to hegemonic masculinity less than the average man and that hegemonic masculinity may have decreased as a result of the program. Also, the three participants who endorsed a greater degree of traditional masculine ideology prior to the program - relative to other participants in this study – were observed to be the least well-adjusted. This means that clinical observations of their presentation included: lower self-

confidence and self-esteem, higher anxiety and reticence for emotional disclosure, and more severe symptoms of depression.

The three who scored highest on hegemonic masculinity had a mean of 2.47 before the program. The seven other participants had a mean of 1.71 prior to the program. Subsequent to the MTP, the mean of the 3 noted men was 1.59, and the seven remaining participants scored 1.25. Comparing this with Levant et al.,'s (2007) normative sample, this may indicate not only that these three participants scored higher on hegemonic masculinity, but the fact that they were the least well-adjusted may indicate that hegemonic masculinity may be a defense mechanism to compensate for a being vulnerable and weak. This is consistent with men's gender role conflict that is associated with depression in that many men who have depression have been reported to perceive themselves as weak and vulnerable.

Table 1. Helpful Processes

Processes	*Participants*	*%*	*Occurrences*
Active Engagement	9	90%	14
General Group Setting	8	80%	8
All-Male Group Setting	8	80%	8

Table 2. Helpful Interventions

Interventions	*Participants*	*%*	*Occurrences*
Communication Skills Training	10	100%	18
Therapeutic Enactment	9	90%	15
Guided Autobiography	9	90%	13
Cognitive Distortions Training	6	60%	10

Table 3. Themes of the Reported Changes

Changes	*Participants*	*%*	*Occurrences*
Connection	10	100%	35
Insight	10	100%	32
Support	8	80%	16
Positive mood	7	70%	12
Improved social functioning	7	70%	12
Self-confidence	6	60%	14
Normalization	5	50%	9
Emotion Awareness	5	50%	5
Reduction in guilt	4	40%	5
Motivation	4	40%	4
Self-esteem	3	30%	5
Catharsis	3	30%	3
Energy levels	3	30%	3

Table 4. Hindering/Wish List Items

Themes	*Participants*	*%*	*Occurrences*
Conceptual learning	6	60%	8
Rushed	4	40%	9

Table 5. MRNI-R Pre and Post Scores of Each Participant

Participant #	*Pre*	*Post*	*Difference*
1	3.11	1.61	1.50
2	1.95	1.41	0.54
3	2.18	1.57	0.61
4	2.12	1.59	0.53
5	1.93	1.18	0.75
6	1.80	1.16	0.64
7	1.52	1.39	0.13
8	1.61	1.23	0.38
9	1.59	1.16	0.43
10	1.57	1.25	0.32
Mean	**1.94**	**1.36**	**0.58**

Note. Items were scored on a 1-7 scale; 1 = Strongly Disagree and 7 = Strongly Agree.

3.1 Processes

Active Engagement (14 occurrences, 90% participation). As described in the literature review, Active Engagement refers to an experiential learning delivery format where participants are engaged in a relevant activity and interactive discussion in which they experience and explore the target knowledge or skill in the present moment. This is in contrast with traditional learning methods that involve the speaker or teacher presenting to a passive audience.

Nine out of the ten participants explicitly reported that they preferred engaging in activities over presentational learning. This seems to indicate that the participants prefer learning methods that foster embodied learning through experiencing and exploring (i.e., being and doing). Nonetheless, this does not negate the importance of conceptual knowledge, because this is precisely what must be integrated into *experience*. These results suggest that the participants preferred this delivery format because it helped them to stay engaged, foster insight, and retain the skills and knowledge that were taught. The following quotes illustrate this:

> "There was a lot of interaction and it made it easier to stay engaged. " (Participant 7)

> "The teaching parts – the presentations - were not as impactful as the stuff where we actually did things…I think hands on is better." (Participant 4)

> "I saw things from a different perspective embodying the characters." (Participant 3)

General group setting (8 occurrences, 80% participation). As discussed more in-depth in the literature review, the general group setting refers to a group of participants and facilitators who share a therapeutic space where the group rules include respect, confidentiality, constructive feedback, and turn-taking that help to foster an atmosphere of trust, safety, and openness, to promote connection, support, normalization, and exploration.

The results suggest that the participants reported their preference for group or individual therapy would depend on the context of the issue or issues they faced. This means that the issue(s) they potentially would face determines whether they would seek out individual or group therapy. For example, one participant reported that he previously sought individual therapy to help him grieve over several deaths in a short time, whereas he sought group therapy in the MTP to help him come to terms with a significant event that happened in the past in order to move forward in his life.

Another factor that suggests the context-dependent nature as to the preference of group or individual therapy is the issue of privacy as, for example, one participant reported that he would not venture into group therapy for issues that are particularly private or that he had not first explored in one-on-one counselling. Here are several examples from various participants to further illustrate these findings:

> "If I am comfortable talking about a certain subject in a group setting, then I would prefer it over individual therapy, because I can then relate my own experiences to those of others and use that to encourage my own steps forward. I would prefer individual therapy to broach and explore subjects

> I'm not comfortable speaking with in front of others, or have not spoken about before." (Participant 9)

> "The nice thing in the group setting was a lot of people shared the same fears, problems, and issues as one another. There was a comfort in knowing that you were not alone in how you felt because there are real people sitting all around you sharing and showing emotional responses to the same thing as you. In individual counselling, I never really got that assurance that my problem was taken on by many others like me, and that I was not alone in it. Rather, it focused a lot of my own perception and how I felt about each thing and worked things out on an internal level that I probably did not get in group counselling. Perhaps I am lucky, but I found both to be effective for what I needed. In individual counselling I was trying to figure out a way to grieve consecutive deaths in a small amount of time in my family, and in group counselling I was shedding a part of the past that I needed to in order to be more ok with myself." (Participant 6)

All-male group setting (8 occurrences, 80% participation). The all-male group setting refers to the participants in the group who all self-identify as men based on a pre-assessment of their demographics. Group members reported that an all-male group setting fostered feelings of safety and trust in sharing personal challenges and uncensored thoughts and feelings. In addition, the all-male group setting was reported to provide cohesion with many of the members because they felt that most men share similar

personal challenges and that there are few other places where men can gather to share, learn, and receive constructive feedback in a safe, trusting, and positive social environment. Note: Participant 9 reported a helpful, hindering, and neutral effect that the all-male group setting had for them and that they would prefer a mixed-gender group setting. The following quotes further demonstrate this:

> “It was an incredible space for myself and other men to be able to speak about issues, as it would be difficult to do anywhere else. The group sense and that it was all men made it easier.” (Participant 9)

> "[The all-male group setting] was helpful because…I suspect it also allowed us to have a more consistent narrative in the group…what I mean is that the patterns of trauma were similar in some regards. I remember shitty fathers came up a fair bit. I think it also allowed us to understand each other’s pain better…father issues was just an example. I think only men in the group made the narratives similar, but if women were included there would have been two narratives" (Participant 4)

> "I found the all-male setting helpful because I can behave differently with women around. For example, I may not say some things because I'm afraid to offend a female member and/or I'm afraid they may dislike me for what I've said. So I felt I could speak more freely and not have to work to speak in a more sensitive manner. There are things we can't say or talk about in front of women (or, at, least feel comfortable doing so). Men

> don't act the same around women as they would in a female-free setting. I think that the main hindrance would be sexual tension that leads to nervousness and hence difficulty in relaxing and be ourselves. I don't think that I would allow myself to be emotional in front of girls because I'd want to appear macho. I guess that being in a group of guys enhances the feeling of being in a brotherhood-like atmosphere and becomes an additional factor that we have in common, which facilitates bonding. After all, finding things in common can be hard in a group because we have different interests, habits, beliefs, etc." (Participant 2)

3.2 Interventions

Communication skills training (18 occurrences, 100% participation). This intervention refers to providing psycho-education and experiential learning via role-plays in paraphrasing, reflecting feelings, and providing constructive feedback. For example, participants were asked to use sentence stems such as "what I noticed/heard is...and the effect that it this had on me was...”. This is proposed to lead to non-defensive communication because it respects the intentions of both parties and allows each party to retain their own experience devoid of shame-based language.

Eight of the eighteen occurrences were explicitly reported as improving participants’ social functioning. As a result of communication skills training, the participants also reported: (a) a greater sense of connection with others that they interacted with on a daily basis, (b) having deeper conversations from a focus on "experience" rather than "accusation" that resulted in increased connection and fostered greater self-agency for both parties, and (c) experiencing greater comfort and efficacy in

interacting with others and getting their point across. In addition, participants reported attaining greater value and skill on how to be assertive without being aggressive as a result of this training. Several examples follow:

> “Before I used to be abrasive but now I value constructive communication more and know how to implement constructive communication as a result of the training. Previously, I was never happy with I how I presented myself. Now I slow down and listen to what people are actually saying, and it actually works much better because people love to talk about themselves. I can be assertive now but not to the point of being fascist.” (Participant 1)

> “The effects are that people are responding patiently from using the communication skills. I’m more comfortable keeping conversations going. Conversations are not so superficial. There’s something more slowed down. When other people do it to me it feels really good to get acknowledged about what I’m saying. Bottom line - more connection.” (Participant 3)

> “I’m more comfortable talking with people in general conversations, especially my social life. Before I felt that I wasn’t really listening to people. Now I try to understand and expand, and use open-ended questions. And I get to know them on a deeper level. Before I tried expanding, but not on an emotional level. Now I expand at an emotional

level. Now I don't try to push my agenda on other people and realize it's better to just understand them. I'm giving them more autonomy instead imposing expectations. Finding small connections is nice. Not imposing frees me up a bit and this is less stressful, and it's now easygoing. It made a big change. I get to know others better, and they are more comfortable because I'm being more understanding." (Participant 10)

Therapeutic Enactment (15 occurrences, 90% participation). Therapeutic Enactment (TE) pertains to an action-based, process-experiential, group therapeutic modality that functions to mimic lived experience to explore current implicit memories and form new implicit memories that are more adaptive to the client's current functioning. As a result of the Therapeutic Enactment component of the program, participants reported greater: insight into their own schemas, motivation from witnessing others' experiences, and acceptance and normalization through being witness to others' therapeutic repair. In addition, participants reported feeling a deeper sense of connection as a result of the authentic emotional experiences witnessed in the TE's that they participated in. Below are several quotes that illustrate these results:

> "I saw things from different perspectives embodying the characters. It was way more personal than I thought it was going to be. I was affected by X's because I went through something similar and you know it's in there but pushed down so when you actually see it bubbles up. The TE allows you to resolve it. It empowers you to move forward – unsticking them. You learn more about the person too." (Participant 3)

> "It was the most paramount and helpful part of the program. It takes such a weight off your shoulders of what has bottled up over the years and you're forced to confront it. It allowed me to release the baggage I was carrying. It gives you the tools and roadmap so the baggage doesn't come back to get you." (Participant 1)

> "In the Therapeutic Enactment, I got to understand the situation – a more clear understanding about why I felt this way… I got an eagle eye view to see what affected the situation. This helped me realize that I have to be more responsible with people in my life - that I have a bigger role to play than I thought…becoming conscious of it I got a bigger point of view and let go of a lot. I wasn't previously aware that it was a cycle." (Participant 10)

Guided autobiography (13 occurrences, 90% participation). This intervention pertains to exploring one's significant life events and sharing these experiences in a group and receiving feedback about the way in which these experiences impacted self and the other members. The participants reported that this intervention provided insight, fostered feelings of connection and support, facilitated normalization, and promoted trust and a solid foundation from which to work in tackling their schemes in later interventions and throughout the program. The following are some quotes that demonstrate these results:

> "You get to share your story, you get to bond with people and get a chance to relate to people… it helps you understand yourself and know that you're not alone in everyday trials and things that happen in your life.

So, after that was done I got a lot of perspective on life. Before I'd be like 'arghh' I'm kind of alone in the way I feel, so it makes you feel not alone." (Participant 1)

"Listening to other life reviews was helpful because getting to know them a bit better was important for this group because it was a support system and we went so deep. Because it went so deep it helped feel closer to the guys. My own life review was helpful because I actually had to think about what to talk about and recap my life, and…because it went deep it helped to feel closer to the guys." (Participant 3)

Cognitive distortions activity (10 occurrences, 60% participation). The Cognitive Distortions Activity refers to training in identifying and mediating unhelpful thinking styles. The delivery of this intervention consisted of a presentation and small group activity where participants practiced identifying and correcting cognitive distortions. The results suggest that the activity was more helpful than the presentation. In addition, participants found that they gained a greater understanding, reduction in guilt, and sense of control over the generalized and worst-case scenario automatic cognitions they experienced. The following quotes exemplify this:

"When you do these cognitive distortions you kind of feel like you're alone in that sense, like 'everything I do is bad', and it's really powerful to realize that 'ah!', well you know, I think everyone has these feelings, everyone is critical of their past successes and just focus on their failures, so that gives great perspective in how everyone does that. Especially when

the facilitators would say 'yeah, we do this one' and these are the people running the program that are able to say 'well, everyone does them', which makes you more comfortable that now you can identify those negative behaviours and realize that it's quite common. Once you realize what you're doing you can change that, you understand what's happening here instead of just being like 'I'm pissed off' – like you're pissed off and you don't know why. If you're angry or feeling down you can label it and understand it. Once you identify that this is just a distortion, instead of just going on that emotional rollercoaster, you can say 'well, this is what I'm doing. How am I going to correct this?' ". (Participant 1)

"Often I'll think in the worst case scenario, and I'm able to tune into it quicker now…once I'm aware of it I can try and stop it – with some reasonable success." (Participant 7)

3.3 Changes

Social connection (35 occurrences, 100% participation). As discussed in the literature review, social connection relates to (a) interpersonal closeness, and (b) belongingness. Closeness relates to perceived interpersonal: emotional affection, feeling understood, a sense of similarity, and stability in the perceived emotional bond. Belongingness pertains to a sense of inclusion and partnership with the other or the group. 'Social support' differs from 'social connection' in that support is characterized by helping, and connection with bonding. All of the participants reported experiencing

connection during the group therapy. The results suggest that it fostered a solid foundation for all of the other processes and interventions. Here are a few examples:

> "Hearing how people could relate just makes you feel not alone…people you would look at and not think they had problems." (Participant 5)

> "If people don't let you in, it's hard to relate, so the connection and just listening and them having the guts and being in an environment where you can open up - it was nice having my thoughts spoken. But having other people around made it so much better – it solidified it more; it made it more real than say just one person." (Participant 10)

> "The check-ins were one of my favourite parts of the program because it increased the sense of connection with others in the group." (Participant 2)

Insight (32 occurrences, 100% participation). Insight refers to novel understandings that arise which provide clarity or a reconceptualization of past and present experiences and future goals. Participants reported that insight was often gained during the process of Active Engagement (i.e., being and doing), Therapeutic Enactment, and frequently resulted in 'interpersonal learning'. As discussed in the literature review, interpersonal learning relates to gaining new awarenesses and conceptualizations about oneself through the interaction with another person or people. Below are five quotes that illustrate the richness of these findings:

> "Everything he felt and said was parallel to my experience with my parents. It was like watching myself. It made my situation clearer and

allowed me to release emotions I'd been carrying about issues he expressed." (Participant 4)

"Being chosen to be a participant in Therapeutic Enactment I saw things from a different perspective embodying the characters. It was way more personal than thought…I was affected by X's because I went through something similar and you know it's in there but pushed down so when you actually see it bubbles up." (Participant 3)

"For mine, the setting - just sitting down in front of X - it brought me right back. It gave me insight into the feelings…this was the first time I ever talked about it." (Participant 6)

"During the Therapeutic Enactment, I got to understand the situation – a more clear understanding of why I felt this way… I got an eagle eye view to see what affected the situation. This helped me realize I have to be more responsible with people in my life - that I have a bigger role to play than I thought - becoming conscious of it I got a bigger point of view and let go of a lot. I wasn't aware that it was a cycle." (Participant 10)

"When we were talking about feelings, doing active listening and perception checks and other things in the group, and hearing what's

important to others, I start thinking about this about myself." (Participant 7)

Social support (16 occurrences, 80% participation). Participants reported that they primarily received emotional support from other members. This resulted or was associated with 'social connection', as many of the reports explicitly mentioned that, for example, they felt less alone, their experience was normalized, and as a consequence, they felt social support. Here are a few examples that illustrate this:

> "I can look to the guys for support. It's been helpful to daily talk with the support group." (Participant 3)

> "Hearing how people could relate – just makes you feel not alone, it universalizes, and you feel more support." (Participant 5)

> "I was surprised to hear how they went into their deep issues. Hearing others gave me confidence to tell my stories." (Participant 6)

Positive mood (12 occurrences, 70% participation). This theme relates to a more uplifted mood that the participants reported as a result of their experiences in the program. The results reveal that positive mood was not associated with any particular intervention. Rather, it appears to be a culmination of the entire program as suggested in the following quotes:

> "After each day and phase, I felt that I was on an endorphin high. I felt that I was walking tall, very positive and in a positive mood." (Participant 8)

> "I'm more optimistic. Stuff that used to bother me with family doesn't bother me as much." (Participant 4)

> "I feel more content with life than I thought I could." (Participant 6)

Improved social functioning (12 occurrences, 70% participation). This category refers to participants who experienced an improvement in their reported interactions with others in their life. This change appears to be correlated with the communication skills training intervention as this was reported to improve social functioning. As a consequence of improved social functioning, this may suggest that depressive symptoms were mediated, and by extension, a potential decrease in the risk of suicide due to the impact that social connection and support have as buffers against depression and suicide. Here are a few examples that demonstrate improved social functioning:

> "I'm more comfortable talking with people in general conversations, especially my social life. Before I felt that I wasn't really listening to people. Now I try to understand and expand, and use open-ended questions. And I get to know them on a deeper level. Before I tried expanding, but not on an emotional level. Now I expand at an emotional level. Now I don't try to push my agenda to other people and realize it's better to just understand them. I'm giving them more autonomy instead imposing expectations. Finding small connections is nice. Not imposing frees me up a bit and this is less stressful, and it's now easygoing. It made

> a big change. I get to know others better, and they are more comfortable because I'm being more understanding." (Participant 10)

> "Before I used to be abrasive but now I value constructive communication more and know how to implement constructive communication as a result of the training. Previously, I was never happy with how I presented myself. Now I slow down and listen to what people are actually saying, and it actually works much better because people love to talk about themselves. I can be assertive now but not to the point of being fascist." (Participant 1)

> "The effects are that people are responding patiently from using the communication skills. I'm more comfortable keeping conversations going. Conversations are not so superficial. There's something more slowed down. When other people do it to me it feels really good to get acknowledged about what I'm saying. Bottom line - more connection." (Participant 3)

Self-confidence (14 occurrences, 60% participation). Self-confidence pertains to the perceived ability to effectively manage challenges that arise in one's life. It was observed that participants sometimes used the term "confident" to refer to "self-esteem". And, that confidence and self-esteem were occasionally an integrated experience. For example, participant 1 reported that he "can talk to people in public now". This suggests that both skill and self-value may be at work here. The following quotes that represent the

participants' reports regarding improved self-confidence:

> "My self-confidence is quite raised to a point that I have never experienced before. It snowballs to different situations. I can talk to people in public now – if they're receptive to it." (Participant 1)

> "I think you guys doing really good work. I feel like I have the skills from MTP to apply to many aspects of life in career school hobbies – I feel more equipped to have social interactions and more prepared for life." (Participant 3)

Normalization (9 occurrences, 50% participation). Normalization pertains to the novel perception that one's challenging experience or problem is not unique, but is shared with other participants, thus increasing connection, safety, and fostering greater openness and trust. Five of the participants explicitly stated that the group had a universalizing effect on their perception of challenges they faced. Normalization seems intertwined with interpersonal learning to some degree as participants seemed to gain greater compassion for self through witnessing others' experiences. The following are some quotes that demonstrate this:

> "You get to share your story, you get to bond with people and get a chance to understand people. It helps you understand yourself and know that you're not alone in everyday trials and things that happen in your life. So, after that was done I got a lot of perspective on life. Before I'd be like 'arghh' I'm kind of alone in the way I feel, so it makes you feel not alone." (Participant 1)

"Hearing how people could relate – just makes you feel not alone - it universalizes, and you feel more support. People you would look at and not think they had problems." (Participant 5)

Emotion awareness (5 occurrences, 50% participation). Emotion awareness refers to participants who gained a greater awareness or connection with their emotions. The results show that Therapeutic Enactment, the perceived safe space within the group, and the opportunity to experience and explore emotional content were the processes and interventions reported to have elicited emotional awareness. Below are some quotes that represent this:

> "It helped identify a deeper issue of anger and how you feel it's a poison." (Participant 2)
>
> "I didn't know that the Therapeutic Enactment would be that powerful. Having the group there was powerful. It emotionally touched me. I felt pretty comfortable that I could be open. Just having the people there - it made it real cause I felt more connected with people there…." (Participant 10)
>
> "The training was definitely helpful because it kind of gave me a model to be able to work around because when it comes to speaking about my own emotions I just haven't for a very long time so I don't have much practice in dealing with or speaking about my emotions and so it gave me a

> model." (Participant 9)

Reduction in guilt (5 occurrences, 40% participation). This theme pertains to a reduction in the frequency and intensity of feelings of guilt. The findings reveal that a reduction in guilt was often subsequent to normalization. This is significant because guilt is a symptom of depression, and if universalization moderates guilt, then group psychotherapy may be a particularly cogent treatment option for clients who present with acute symptoms of feelings of guilt. Below are some quotes that exemplify a reduction in guilt:

> "I have less of a blame for feeling bad cause I know there are probably reasons and I look for why that might be. Before I had that thought, but now it's a deeper realization that it's okay to feel bad…maybe it was because I heard other people speak of their thoughts and I realized other people go through the same things - that it's okay to feel like that. I have a deeper understanding that people do have the same issues." (Participant 10)

> "I'm focusing less on issues, such as emotional and psychological pain, such as beating myself up regarding academic failures." (Participant 9)

Motivation (4 occurrences, 40% participation). Motivation refers to experiencing greater volition to engage in a certain behavior. The results suggest that participants experienced enhanced motivation to engage in constructive, healthy, and goal-oriented activities or lifestyle changes. Below are a few examples that the participants reported:

> “I’m feeling motivated to get back in the game. To go back to school. I’m also keeping a sleep and exercise log based on Dr. X’s suggestion to get sleep 2 weeks and keep track of food to rule out depression.” (Participant 3)

> “My motivation is a lot different. Before working out was a chore, but now I have internal motivation – it’s not so much a job.” (Participant 6)

> “I’m sobering up a bit, such as not smoking weed as much, and I set a personal goal not to do drugs on weekdays.” (Participant 1)

Self-esteem (5 occurrences, 30% participation). Self-esteem refers to the perception and associated feelings about one’s worth. As delineated in a previous sub-section, participants sometimes termed self-esteem as confidence. The distinction being that confidence is related to the perceived ability to manage challenges, whereas self-esteem refers to the perception of one’s own intrinsic value. The findings suggest that participants experienced greater autonomy and self-respect - and assertiveness - as a result of the program. The following quotes have been selected to represent the reports of greater self-esteem:

> “At work I’ve been a little more demanding for my needs versus their needs whereas before I was just like ‘yeah, yeah, anything to please them’.” (Participant 1)

> "I have more self-respect, boundaries, and autonomy now. I'm able to be true to myself and not have to explain myself or feel like I have to do what other people want me to do." (Participant 7)

Catharsis (3 occurrences, 30% participation). This refers to participants who had a cathartic experience as a result of their emotional expression. Catharsis can be defined as the expression of emotion that results in an abrupt shift in perception (i.e., insight) accompanied by surges of affect that alleviate previously inhibited feelings (e.g., anger or sadness) associated with implicit memories of relational or other traumatic experiences (Substance Abuse and Mental Health Services Administration, 1999). The results show that the Guided Autobiography (i.e., Life Review) and Therapeutic Enactment were the interventions associated with these results the participants reported.

> "The life reviews built trust and were a huge emotional release for me…it made my situation clearer and allowed me to release emotions I'd been carrying about issues." (Participant 4)

> "Just getting stuff off my chest helped me so much already, and so was giving encouragement to guys to do it if they wanted to." (Participant 6)

> "The life review was most helpful because I was able to finally talk about and show emotions, and have it reflected back in a useful way by the group." (Participant 9)

Energy levels (3 occurrences, 30% participation). This theme refers to the participants' reports of greater levels of energy as a result of their experience in the

program. The reports suggest that higher energy levels were as a result of the gestalt of the program, and not an individual aspect. Participants recounted the following that demonstrates this change in energy levels:

> "For the closing that day I was in a euphoric state…after I felt an 'alive' energy. That was the point I started to see things in more vibrancy." (Participant 6)

> "I'm more motivated for everything (e.g., cleaning, chores, made plans for next semester and figure out how to do them). It's just a lot easier to do things. I have the energy to do things." (Participant 4)

3.4 Hindering/Wish List

This sub-section addresses aspects of the program that participants did not find helpful and what they would have liked modified. Hindering and wish list themes revealed that aspects of the program which comprised of presentations - or what was not interactive – was reported as being hindering (8 occurrences, 60% participation), and that the second-half of the the last day was rushed (9 occurrences, 40% participation). Thus, the participants reported desiring Active Engagement to presentations, and more time in the program – especially during the final day.

Conceptual learning (8 occurrences, 60% participation). Conceptual learning refers to traditional instruction that involves a teacher or facilitator presenting information to a passive audience with minimal or no interaction with the audience. A common example would be PowerPoint presentations. Here are a few examples of participants who reported that the 3 presentations in the entire program were not as

helpful as the majority of the program in which they engaged in group activities:

> "Intrinsically most guys know [about emotions]. Maybe there needs to be more training about what to do about the emotions." (Participant 6)

> "The emotional awareness presentation was not too helpful – maybe something more practical would be." (Participant 3)

Rushed (9 occurrences, 40% participation). This theme relates to the participants' reports that there was not adequate time to address some of the activities or material taught – particularly the second half of the last day of the program. Below are some examples:

> "This component felt rushed. I would have liked it less rushed…not everyone got to experience it." (Participant 7)

> "More time was needed on it because it felt rushed." (Participant 8)

Chapter 4: Discussion

The current study examined themes that relate to the processes, components, and changes regarding the experiences of young adult men aged 18-32 in a group counselling program for symptoms of depression. The broader objective was to assess which interventions and processes were helpful, in what capacity, and the impact that various aspects of the program had on the participants during and after the program.

Several key discoveries have resulted from this study. The first is that there seem to be some parallels between the reported changes and common symptoms of depression, which may indicate specific aspects of group therapy that can mediate certain symptoms of depression. Second, both action-based interventions and interpersonal sharing seem to be as equally helpful to men – which is a surprise because the literature suggests that men prefer activities rather than interpersonal sharing. Third, that the teaching delivery of Active Engagement was unanimously preferred over presentational learning, and that this may be a preference across genders due to embodied learning being at the core of having the capacity to implement what was learned.

Fourth, that most participants seem more comfortable in a single-gender group setting, and how other research in the literature shows that it is common for a single-gender group setting to be preferred for both genders because there are gender-specific issues that arise for various presenting problems (e.g., depression, substance abuse, etc.) in which participants would otherwise feel uncomfortable disclosing in a mixed-gender setting. And fifth, that a preference for group or individual therapy is not an either or preference for men as clinical writings suggest; instead men's preference is context-

dependent in which each format has its place and utility for a client depending on the particular circumstances.

Parallels. Upon analysis of the themes relating to the changes that the participants reported it seems that many of the benefits mirror the antitheses of several common symptoms of depression. To demonstrate this, I will reiterate the common symptoms of depression, then list and analyze the parallels of the reported changes. The common symptoms of depression that are associated with the changes reported are social isolation, a lack of clear thinking, low mood, impeded social functioning, feelings of guilt, a lack of motivation, low self-esteem, and decreased energy levels.

Thus, the changes that were reported as being associated with the antitheses of the symptoms of depression are social connection (35 occurrences, 100% participation), insight (32 occurrences, 100% participation), positive mood (12 occurrences, 70% participation), improved social functioning (12 occurrences, 70% participation), a reduction in feelings of guilt (5 occurrences, 40% participation), greater motivation (4 occurrences, 40% participation), higher self-esteem (5 occurrences, 30% participation), and enhanced energy levels (3 occurrences, 30% participation).

Some of the categories of the changes that are associated with the antitheses of common symptoms of depression were reported to be a direct consequence of specific processes or components of the program. Social connection and improved social functioning were often reported to be a result of the communication skills training component. A reduction in guilt was associated with normalization as a result of the all-male group setting. Insight was frequently reported as being a result of Therapeutic Enactment, which is strongly associated with interpersonal learning. Insight can be

correlated with the symptom of depression pertaining to a lack of clear thinking because insight provides *clarity* of perception. Insight was often reported to be a result of Therapeutic Enactment – especially from witnessing another participant's enactment. And finally, many of the participants reported that the all-male setting, group format, and communications skills training mediated their depressive symptoms of guilt, social withdrawal, and social dysfunction by producing normalization, improved social functioning, social connection and support, positive affect, and insight.

Action-based interventions and traditional masculine ideology. Another interesting finding from the results of this study is that participants found action-based interventions (i.e., Therapeutic Enactment) and interpersonal sharing (i.e., group discussion) to be almost equally as helpful, with the former having slightly more occurrences though both having the same participation rates. Although, this might be because most of the participants ascribed less to traditional masculine ideology as quantitative measures of masculinity revealed that 7 of the 10 participants did not prior to the group. This may have been a reason that many were not averse to emotional vulnerability, as men who ascribe to a high degree of traditional masculine norms are reported to be less apt to emotionally disclose or engage in interpersonal sharing (Good & Brooks, 2005).

For example, the fact that the majority did not adhere to traditional masculinity according to the MRNI-R (Levant et al., 2007) may have had a socializing effect on the minority of those who did score higher on traditional masculine ideology. This may have been a result of social modeling (Yalom, 2005) that promoted greater openness in the culture of the group. An insight is that the participants who scored high on traditional

masculinity were those that presented with a greater degree of maladjustment. This insight will be further discussed in the sub-section pertaining to 'implications'.

Active Engagement. In terms of the delivery format of teaching conceptual knowledge (e.g., emotional awareness) and skills (e.g., communication activities) in the program, 9 of the 10 participants preferred engaging in activities over presentational learning. This seems to indicate that the participants prefer learning methods that foster embodied learning – experiencing and exploring (or being and doing). In spite of that, it does not negate the importance of conceptual knowledge, because this is precisely what must be integrated into one's *experience*.

Single-gender group setting. Group members reported that an all-male group setting resulted in feeling more comfortable in sharing personal challenges and uncensored thoughts and feelings. In addition, the all-male group setting was reported to provide cohesion with many of the members because they felt that most men share similar personal challenges and that there are few other places where men can gather to share, learn, and receive constructive feedback in a safe, trusting, and positive social environment.

Group versus individual psychotherapy. The participants in this study reported that the helpfulness of the group setting depended on the nature of the concern, how private the issue was, and whether they had explored it prior to the group, as it would be "anxiety-provoking to explore the concern for the first time in a group of strangers." (Participant 6).

4.1 Theoretical Agreement

Social connection. Social connection and improved social functioning were often reported to be a result of the communication skills training component. This is significant because interpersonal efficacy enhances the quality of interpersonal relationships, which in turn, provide social connection and social support that, as a result, mediates depression (Lee, Draper, & Lee, 2001; Sayal et al., 2002). Pertaining to the normalizing effect that the all-male group setting had on the participants, research suggests that normalization of thoughts and feelings result in social connection and support, which, as a consequence, elicits a soothing effect that contributes to greater positive affect and perspective (Shepard, 2002).

Insight & mood. Relating to the impact that the program had on promoting clarity of perception in seeing the “big picture”, this type of perspective has been found to relate to one's experience of meaning in life (Hicks & King, 2007). And, meaning in life is associated with depression, stress, optimism, and happiness in life (Mascaro & Rosen, 2005; Reker, Peacock & Wong, 1987; Ryff, 1989; Zika & Chamberlain, 1992). Having perspective contributes to positive affect because people often base their evaluations on the information at hand, which does not frequently take in to account all of the variables (i.e., a broader and more complete scope/assessment) (Hicks & King, 2007). Thus, insight can enhance positive affect and potentially mediate low mood associated with depression, and by extension, decrease the risk of suicide.

Preference for single-gender therapy. The finding that men tend to prefer single-gender groups to mixed-gender groups aligns with clinical writings and research in the literature, as single-gender group therapy compared with mixed-gender therapy has

been shown to provide the opportunity for participants to explore and discuss gender-specific concerns associated with the presenting problem in a setting that is emotionally safe (Greenfield et al., 2013; Powell, 2006).

All-male groups have been found to foster a safe space for men to be vulnerable and learn that other men have similar challenges or fears (i.e., normalization), and this may decrease social and emotional isolation by offering interpersonal and emotional connection (Ogrodniczuk & Oliffe, 2009). For example, these authors proposed that grief might be at the core of many men's therapy issues. However, it seems that virtually any mental health challenge can be viewed as a loss of one kind or another. For example, schizophrenia can be viewed as a loss of one's perceptual control. Anxiety can be construed as a loss of one's self-esteem. Although, depression is a common co-morbid disorder (Kessler, Berglund, Demler, Jin, Koretz, Merikangas, Rush, Walters, & Wang, 2003), thus it may make sense that depression is associated with a loss of some kind if it is co-morbid with other disorders that also involve, in essence, a loss or inability to meet or attain a need or level of functioning. Although, this would also mean that loss is not only unique to being at the core of many men's issues in therapy, but would apply to both genders as well.

Masculinity, action-based interventions, and interpersonal sharing. As discussed in the literature review, research (Caldwell & Peplau, 1982; Good & Brooks, 2005; Englar-Carlson & Kiselica, 2013) relating to whether men prefer action-oriented group therapy versus an interpersonal sharing focus suggests that men tend to prefer therapeutic groups that are action-oriented (e.g., role-playing) instead of groups that are only conversational in nature because male interactions are often based around an activity

instead of primarily interpersonal sharing. The results of this study seem to contrast with the literature, as the participants rated interpersonal sharing very helpful – almost equally as helpful as engaging in activities.

Active Engagement transcends gender preferences. The result pertaining to the participants of this study preferring a teaching method, such as Active Engagement, that fosters embodied learning is congruent with the literature. This is not to say that it is unique to what men prefer. Embodied learning seems to be the most efficient form of learning in general for material that will be applied to actual experience because concepts, skills, and experiences are first interpreted (consciously and unconsciously) (Siegel, 2015) through perceptual, somatosensory, and procedural memory (imaginal AND in vivo) (Kontra, Goldin-Meadow, & Beilock, 2012; Siegel, 2015), and these representations that are formed become connected to associative memory that create reference points through which we understand one variable through the likeness of another variable (Hofstadter & Sander, 2013).

Chapter 5: Conclusion

5.1 Implications

Connection and support mediate depression. The finding that interpersonal efficacy leads to more positive social relationships which, in turn, lead to connection and support, is significant because connection and support may provide a buffer against depression (Sayal et al., 2002; Williams & Galliher, 2006). This is especially salient for men whose expression of depression involves social isolation as many men have been reported to socially isolate themselves and avoid feelings of vulnerability and powerlessness (O'Neil, 2008). Thus, being in a group could allow men to experience empowerment while still being in a social support structure and receiving the benefits of connection and support to mediate symptoms of depression and risk of suicide.

The impact of normalization on feelings of guilt. The group setting invariably involves interpersonal sharing, and interpersonal sharing might help to combat restrictive emotionality that is present in traditional masculine ideology (Shepard, 2002). This may also lead to normalization as a result of receiving and accepting positive feedback, thus promoting a reduction in guilt. If group therapy has a common effect of normalization, and if normalization reduces guilt, then groups may be a viable option for men who have a significant presentation of guilt as a depressive symptom. Thus, evaluating which of the symptoms of depression are most prevalent for each client may help to structure the group in a manner that can best mediate the client's unique presentation of depression.

Preferences for group or individual therapy. A preference for group therapy seems to depend on the context of a range of factors previously noted. The theme arising from the participants' experiences in this study suggest that men might prefer individual therapy for very sensitive challenges that were not previously explored and group therapy

for known challenges that were not too intimate to share with potential strangers. Again, the context-dependent nature of what is being shared and the demographics of the participants seem to impact the helpfulness and preference for the particular format of therapy implemented. This knowledge might help clinicians evaluate the best fit for clients according to the nature of their presenting concern, age, personality, gender, and culture.

Social modeling, normalization, & openness. Pertaining to the implications for the participants who preferred a single-gender to a mixed-gender group setting are that single-gender groups seem to foster normalization and a greater openness to share concerns that are common to the same gender. As such, men seem to prefer the single-gender group setting in general because there are gender-specific issues that commonly arise. Thus, all-male setting is the format in which they feel most comfortable disclosing such concerns.

Masculine gender roles & action-based interventions. The result pertaining to participants finding both action-oriented interventions and interpersonal sharing equally as helpful may suggest that younger generations of men might not ascribe to traditional masculinity as much as some literature suggests. And, that for those who do ascribe to traditional masculinity, they might have greater maladjustment because hegemonic masculinity seems to be marked by a fear of vulnerability, which implies a lack of trust in other men. Therefore, structuring a group that includes a slight majority of participants who are somewhat better well-adjusted, along with those less well-adjusted, may be fruitful because well-adjusted clients might become role models that help shape the culture of the group to foster more adaptive conceptions of masculinity, and thereby

promote greater openness and trust among men in the group.

Gender & Active Engagement. The implications for the preference of Active Engagement seem to indicate that men do prefer learning methods that foster embodied learning; however, this may not only extend to men because the same learning processes seem to exist for women as well. There seems to be a need for employing psycho-educational teaching methods in counselling that foster embodied learning because what is taught will only be integrated into lived experience if the learning method mirrors real-life *experience*.

Summary & implications for group psychotherapists. There are several implications as a result of this study that those in the mental health field who conduct group psychotherapy may find helpful to consider. First, utilizing a delivery method that fosters embodied learning, such as Active Engagement, when imparting knowledge and skills seem to be instrumental in integrating it into one's functional repertoire for application to lived experience. Second, it may be beneficial to include well-adjusted participants as a slight majority of the group, so as to provide a socializing influence (i.e., modeling) to less well-adjusted clients. And third, pay close attention to the stage of exploration and degree of sensitivity particularly for younger male clients, as they may initially find individual counseling more helpful at early phases of treatment.

5.2 Limitations

As determined in the final follow-up questions, many participants found individual therapy helpful in addition to group therapy, nevertheless; the framing of the questions in the initial interview about whether participants found group therapy advantageous may have unintentionally resulted in an ambiguity that they preferred

group therapy because individual therapy was not originally asked about. Not all of the participants reported back in the follow-up interview. Thus, there is a slight gap as to the preferences, and thus the conclusion of the context-dependent preference for group and individual therapy of *all* of the participants. Nevertheless, those who did reported that they found group therapy beneficial but they did *not* have a set preference because of its context-dependent nature.

Another limitation is that the sample size is small and, therefore, the results cannot be generalized. Even so, these findings may help to inspire future studies to increase or decrease the weight of evidence found in this thesis. This sample also consisted of participants that were mostly Caucasian and identified with Canadian culture. Thus, this study was limited in its diversity as none of the participants were raised in collectivist societies, as all were socialized in Canada for the vast majority or a significant portion of their lives.

5.3 Future Research

Future qualitative research investigating the parallels between the impact that a group therapy program - such as the one in this study - has on men's symptoms of depression may be a useful endeavor because it may help to illuminate which processes or interventions mediate certain symptoms of depression. In terms of clinical directions, it may be helpful to take into account the nature of the client's specific maladjustment, clinical disorder, age, personality, gender, and culture to determine the best fit for group or individual therapy because a preference for the type of treatment setting seems to be highly context-dependent, and not an either/or preference. Research that aims to

investigate existing measures or develop new measures that take these factors into account may prove more useful.

Pertaining to the preference for single-gender groups, it might be advantageous to investigate what the gender-specific concerns are that men have to see if there are any generalizable themes, as this may help provide criteria to inform clinicians when a mixed-gender group would more appropriate.

And finally, investigating group programs for men with depression that comprise of a greater diversity of clients might illuminate whether there are any differences in the helpfulness of interventions as a result of different cultures and age groups. For example, a program that includes older men and younger men may assist in providing greater socialization and transformation of masculinity.

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Appendices

Appendix A: Curriculum

Phase I	June 20	Informed consent and pre-testing
		Introduction presentation
		Introduction dyads
		Communication skills training
		Lunch with assigned partner: Adventures/unusual activities
		Life Review
		Closing: What are you taking?
	June 21	Check in
		Life Review
		Lunch
		Life Review
		Difficult conversations demo
		Difficult conversations breakout groups
		Check out: What are you taking?
	June 22	Check in
		Emotional awareness presentation
		Difficult conversation breakout groups
		Lunch
		Accountability pairing homework
		Cognitive distortions group activity
		Wrap up: What will you miss?

Phase II	June 27	Group check in
		Training in reflecting feelings
		Dyadic interviews on impact of program on week
		Lunch
		Two enactments
		Closing
	June 28th	Check in
		Enactment
		Lunch
		Triads: Where are you now and where do you want to be in your future?
		Reporting triadic work in large group
		Instructions on preparing Coat of Arms and assignment of skills, aptitudes and values sheets
		Closing
	June 29th	Check in
		Enactments
		Lunch
		Personal strengths cards and SMART goals sheets
		Screening of video demonstration
		Relapse prevention training
		Coat of Arms presentation
		Closing: What you'll miss and what you're taking away
		Post-testing and group photo