

Understandings of Men's Depression in Published Research,
News Media Portrayals, and Men's Accounts of Their Experiences

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Abstract

Within the next two decades, depression is predicted to become the leading cause of disease burden in developed countries, and the second leading cause of disease burden globally. There is a relatively large body of research on women's experiences of depression, but research on men's depression, and their experiences with depression, has been fragmented. The aim of this dissertation is to contribute to the understanding of depression in men through the triangulation of three diverse sources of data that deal with men's experiences of depression. These data sources are: existing published research studies, media portrayals, and in-depth interviews with men.

Applying a systematic review methodology, the first study explores current knowledge about the factors associated with depressive symptoms in men. These factors include social and demographic factors, occupational factors, health behavioural factors, and psychological or cognitive factors. I discuss the relevance of these findings in relation to diathesis-stress models of depression, and to theories of pathoplasticity which describe an individual's vulnerability to potential stressors.

In the second study, I extend the theory that 'softer' masculinities are becoming increasingly valued in modern society, through an investigation of how depressed men are positioned by particular discourses in news media articles. I explore news media portrayals of men's communication about their depression in relation to theories of stigma and masculinity. The findings of this study highlight the role media can play in reproducing or challenging such stigma.

The third and final study addresses the limited research on men's subjectivities of distress. I add to the body of knowledge about men's discourses of depression by exploring how men draw on medical understandings of depression and how they talk about the broader social contexts of their experiences. The focus of this study is to explore the understandings of depression experienced by a group of Australian men

with high depressive symptoms. This study utilises a thematic analytic framework to provide an overview of men's subjectivities of depression. The findings of this study provide more depth to knowledge of men's understandings of depression.

This dissertation has several theoretical contributions and implications for clinical practice, public health services, and policy makers. The findings provide health practitioners and the public health sector with comprehensive knowledge about the relevant factors associated with men's depression. This dissertation also presents an overview of factors discussed by a group of men with depression. This provides an understanding of how men make sense of their condition. The research findings highlight how discourses of men's depression can work to dispel or reproduce stigma around men's mental health concerns. These findings are particularly relevant to policy makers for their debate and development of the gender equality in mental health outcomes.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

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Brett Scholz

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「裏に裏がある」といつも信じていて、裏を探しに論文を書きました。
色々な人に裏を見せて頂きました。有難う

"Let me tell you all what it's like being male, middle-class, and white: it's a bitch"
- Ben Folds

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Works Within This Thesis

- Scholz, B.**, Crabb, S., & Wittert, G.W. (2014). “‘We’ve got to break down the shame’: Portrayals of men’s depression”, *Qualitative Health Research*, 24(12), 1648-1657.
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Other Works

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Chapter 1

Men and Depression: An Overview

1.1 Introduction

Depression has been predicted to become the leading cause of disease burden within developed countries by the year 2030 (Mathers & Loncar, 2006), and it already accounts for almost 5% of disease burden in men in Australia (Australian Bureau of Statistics, 2010a). Each year, 6.2% of the population of Australia receive a diagnosis of depression or other affective disorder (Australian Bureau of Statistics, 2008). It has been suggested that not all men who experience depression are diagnosed with the condition – perhaps due to the stigma surrounding the condition, the associated invisibility of depression, and men’s reported lower likelihood of seeking help for mental health concerns (Addis, 2008; Addis, Mansfield, & Syzdek, 2010; Rice, Fallon, & Bambling, 2012).

The focus of this dissertation is to build a greater understanding of men’s depression through the analysis of three diverse sources of data. Across three studies, I examine the current scientific understandings about factors associated with depressive symptom development, analyse the ways in which men are portrayed in news media in relation to their communication about depression, and map the major themes oriented to by men in discussion about their experiences with depression.

This first chapter sets out to describe the increasing body of research concerned with men’s experience of depression, in order to provide the context and justification for the dissertation. Depression has been long considered a predominantly female experience and, as a result, understandings of men’s experiences of depression are fragmented (Addis, 2008). In the upcoming sections of this chapter, I provide a contextual overview of depression in terms of biomedical and other models, and then

discuss the background of current knowledge and practice in men's experiences with depression. The aims of the research program detailed in this thesis, and an overview of the subsequent chapters, are provided at the end of this chapter.

1.2 Defining Depression

Depression has been described as a cycle of negative feelings (Westerbeek & Mutsaers, 2009). It was famously likened to a 'black dog' by Winston Churchill, in reference to cultural and literary images of death and the underworld (Bartley, 2009). The experience of depression has been likened to hating everything (Wander, 2011), being "at war with [oneself]" (Pobjie, 2011), and to a "complete fog" (Wing of Madness Depression Guide, 2013). At the same time, the impact of depression has been downplayed in common discourse. Depression has become something of a 'default' mental illness, likened to a mental common cold, although this generalisation has been criticised for how it fails to recognise the stigma and the shame experienced by sufferers (Westerbeek & Mutsaers, 2009).

In terms of diagnostic criteria, depression can be summarised as a low mood which is unreactive to circumstance, with additional symptoms distinguishing the condition from general sadness (National Institute of Clinical Excellence, 2004). To be given a diagnosis of depression, according to criteria established in the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV) (American Psychiatric Association, 2000), an individual must have had five depressive symptoms during a 2-week period – at least one of which must be a depressed mood most of the day on most days, or a significant loss of interest or pleasure in most activities (American Psychiatric Association, 2000). The other possible symptoms outlined by the American Psychiatric Association include significant weight or appetite gain or loss (unless explained by dieting), insomnia or hypersomnia most days, psychomotor agitation or retardation on

most days, fatigue nearly every day, a feeling of worthlessness or excessive guilt most days, a loss of concentration, and suicidal ideation or recurrent thoughts of death.

The symptoms of depression are diverse, and are typically quantified (for screening or research purposes) by self-report measures. Two of the more common self-report measures include the Beck Depression Inventory (BDI) (Beck, Steer, & Carbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Center for the Epidemiological Studies – Depression scale (CES-D) (Radloff, 1977). Both the BDI and the CES-D measure a range of depressive symptoms including crying, sadness, loss of appetite, loss of interest, changes in sleep, and low libido (Beck, Steer, & Carbin, 1988; Radloff, 1977). The self-report measures do not provide a diagnosis of depression, although they are significantly correlated with each other and with diagnoses based on clinical interviews (Lewinsohn & Teri, 1982; Roberts & Vernon, 1982). Clinical interview classification systems construct depression in terms of medication response; that is, historically, such classifications arose in relation to sorting of depressive disorders based on the drugs to which they were responsive (Hirshbein, 2009). Hirshbein (2009) suggests that in the decades following World War II, depression became defined as the range of conditions that responded to medication for depression. Thus the criteria of these classification systems serve to construct depression as a psychopathology with a biomedical basis.

1.2.1 Theories of depression

In this section, I provide an overview of some of the key theories of depression. I begin with biomedical theory – one of the most dominant models of disease. I then discuss cognitive and biopsychosocial theories of depression.

Biomedical theories

The biomedical framework has been the most dominant understanding of disease for decades (Engel, 1977). A key assumption of the biomedical framework is that disease can be measured in terms of biomedical variables. To this end, the biomedical understandings focus on physical processes of disease. Various biological systems have been suggested to play a role in the development of depression. For instance, the vascular depression hypothesis suggests that cerebrovascular disease may be related to depressive symptoms (Alexopoulos et al., 1997). Another possible biological explanation for depression is that hormonal differences in individuals bring about depressive symptoms (Nolen-Hoeksema, 1987). In fact, mental illness generally – and depression specifically – is dominantly understood and operationalised in terms of a biomedical framework (Galasiński, 2008; Kutchins & Kirk, 1999).

As the dominant model of depressive disorders, biomedical theory has shaped and been shaped by the treatment of depression. Indeed, Deacon (2013) highlights that the way pharmaceutical marketers refer to particular medications (such as “mood stabilisers” to refer to drugs used to treat mood shifts) make it appear that drugs are targeting well-understood biological bases of disorders. A meta-analysis of controlled trials for popular antidepressants, however, indicates that there may be negligible benefits of such drugs over placebo (Kirsch, Moore, Scoboria, & Nicholls, 2002). In fact, with fewer side effects, psychotherapy may be a better alternative to antidepressant medication (Antonuccio, Burns, & Danton, 2002). Turner and Rosenthal (2008) agree that the benefits of antidepressants over placebo are small, but argue that even these benefits are clinically relevant. Regardless, it appears that the dominance of the biomedical model, which emphasises biological bases for depression, leads to the primacy of pharmaceutical treatments.

Despite being dominant, the biomedical framework has been criticised for a number of reasons. One of the criticisms is that understanding mental distress in biomedical terms emphasises the divisive nature of diagnosis – such that those receiving a diagnosis can become treated as ill, irrational, and ‘mad’ (Poole et al., 2012). Such constructions of mental illness may serve to reproduce stigmatisation of those we consider ‘ill’ – potentially further impacting on their mental health. A further criticism of the biomedical theory is that it cannot fully explain all types of ‘illness’. As Wade and Halligan (2004) argue, biomedical theories often ignore the interplay between mental and physical health problems, leading to health care systems with separate service provision for those with physical problems and those with mental health problems.

In terms of depression, specifically, the biomedical theory has been criticised for promising a medical cure through antidepressants, even though mental health concerns may be rooted in social contexts that cannot be treated through medication (Kokanovic, Bendelow, & Philip, 2012; Lafrance, 2007). In interviews with participants with a diagnosis of depression, Kokanovic and colleagues (2012) found that there was a dissonance between each individual’s diagnosis of depression and the ways in which they avoided drawing on biomedical understandings of depression. Participants resisted medicalised discourse through shifting their emphasis to the social, everyday contexts of their distress. At the same time, participants supported medicalised discourses of depression through incorporating narratives of medical diagnosis into their stories of self. Such incorporation of medicalised discourses into participants’ narratives typically characterised their depression as something ‘wrong’ with them (rather than accounting for other contexts such as workplace or relationship stress, for instance). Such findings demonstrate one way in which the biomedical framework of depression may be problematic for patients – they draw on biomedical understandings of their diagnosis,

but these understandings cannot account for, or change, the broader contexts in which they experience their condition.

Another concern with the biomedical approach to depression is that it fails to consider physicians' encounters with depressed patients (Thomas-MacLean & Stoppard, 2004). In interviews with physicians, Thomas-MacLean and Stoppard (2004) found that in interactions with patients, physicians drew on biomedical discourse that constructs depression as having a biological aetiology, and as 'something wrong' with the patient. Simultaneously, physicians move out of a biomedical discourse to deal with social contexts of depression. There were three ways in which dissonance in moving in and out of biomedical discourse was present in physicians' talk about depression. First, depression was constructed as both 'normal' and 'wrong', which could be problematic for patients trying to understand their condition. Second, physicians juxtaposed talk about biological aetiology of depression with metaphoric understandings of depression. Such metaphors included "being in a 'hole' ...[or] being 'lost'" (Thomas-MacLean & Stoppard, 2004, p. 286). While metaphors may be used to describe depression in clinical settings (as I will discuss in greater detail below in section 1.3.1), the juxtaposition of these two discourses might confuse the contexts in which people experience depression. Last, the certainty of the biomedical framework was in contrast to physicians' descriptions of uncertainty relating to the complexity of a depression diagnosis. It seems, therefore, that physicians negotiate multiple understandings of depression that are not well integrated. I do not mean to suggest that these understandings necessarily need to be integrated. Rather, in accordance with Thomas-MacLean and Stoppard's (2004) findings, it seems that those working within healthcare have difficulty dealing with biomedical and personal contexts of depression. Improving understandings of such contexts may be beneficial to patients.

The results of studies of patients' understandings of depression (e.g., Kokanovic et al., 2012) and studies of physicians' understandings of depression (e.g., Thomas-MacLean & Stoppard, 2004) emphasise the complexities associated with diagnosis and treatment of depression. As these studies highlight that there are differences between understandings of depression (biological understandings vs social understandings, for instance), there may value in conducting more research that explores the broader social factors that contribute to our understandings of patients' experiences of depression.

Cognitive theories

Cognitive theories of depression emphasise the nature of cognitions in the development of depression. Specifically, a cognitive approach would suggest that a negative way of thinking and of interpreting the world would give rise to depressive outcomes (Gotlib & Joormann, 2010). In such a view, it is the negative interpretation of events, or the inability to separate from negative thoughts that leads to depression (Blaney, 1977), rather than the events or subjects of thoughts themselves. In other words, the cognitive framework of depression does not focus on the situation that an individual is in (regardless of whether or not the situation is full of stressors), but rather on an individual's perception of the situation.

The most well-developed theories of causation of depression are the cognitive theories of depression that posit that cognitive vulnerabilities exist within some individuals and that these vulnerabilities then interact with stress – generating depression (Haefel & Hames, 2013). These theories are examples of diathesis-stress models, which posit that depression is a result of stressors bringing about depressive symptoms in individuals who are already vulnerable to depression. In other words, such a position would argue that individuals experience stressful events that bring about negative cognitions (Sacco & Beck, 1995). In turn, depressive symptoms arise from

negative cognitions that are repetitive, uncontrollable, and intrusive (Sacco & Beck, 1995).

Cognitive approaches to depression have been criticised for suggesting that depression is a result of negative ways of thinking, but not suggesting why it might be that individuals have these negative cognitive patterns (McBride, Farvolden, & Swallow, 2007). It may, therefore, lead to confusion between the symptoms and causes of depression. For instance, in a cognitive model of depression, a negative worldview may be thought of as a causal factor, which ignores the possibility that the negative worldview may actually be a symptom of an individual's depression.

Another criticism of cognitive approaches to depression is that they locate the cause of depression as internal to an individual (McBride, Farvolden, & Swallow, 2007), thus potentially constructing the individual as responsible for depression. Thus, just like biomedical approaches to depression discussed earlier, cognitive models ignore the range of social factors that might be related to the condition.

Research findings that support theories of cognitive vulnerability to depression include those that support the predictive validity of cognitive vulnerability on depression (Cole et al., 2008; Nolen-Hoeksema, Girgus, & Seligman, 1992). Cognitive vulnerability models of depression are also supported by studies that have found that interventions designed to modify cognitive vulnerabilities are effective in the treatment of depression and may even protect against depression (Haefffel & Hames, 2013). The research presented within this dissertation does not relate specifically to treatment or therapy for depression. For this reason I do not provide an intensive discussion of therapy here, other than to say that particular models of depression relate to particular therapeutic methods. For example, purely biological understandings of depression would suggest a pharmacological treatment, while cognitive understandings of depression would suggest cognitive therapies.

Biopsychosocial theories

While biomedical theories of depression focus on the biological bases of depressive outcomes, and the cognitive theories of depression are concerned with cognitive vulnerabilities to depression, biopsychosocial also incorporate the social contexts in which the individual develops depressive outcomes. Kleinman (1986), for example, challenges the idea of a biological basis of depression and instead demonstrates the social origins of the condition. This model of depression as also having social antecedents draws on how, for example, work and relationship problems give rise to hopelessness and self-defeating concepts of one's life. In turn, such issues create further self-esteem problems, blocks alternative coping strategies, limits resources, and produces interpersonal tensions. Kleinman (1986) argues that this process results in depression.

A biopsychosocial model emphasises the importance of exploring all relevant biological (such as neurotransmitter activity), psychological (such as emotions and cognitions), and social factors (such as interpersonal relations) that might bring about depression. It appears that all of these factors influence one another in an interdependent manner (Gilbert, 2001). Depression, according to this model, is therefore likely to come about as a result of any number of biological, social, and psychological factors that might appear to be independent of one another, but that actually feed into one another in interaction.

It is also important to mention at this stage that biological, psychological, and social factors may also be related to men's depression in pathoplastic relationships. Pathoplasticity refers to a relationship in which biopsychosocial factors and depressive symptoms would influence one another, but not in an aetiological relationship (Klein, Kupfer, & Shea, 1993). Pathoplastic relationships between a range of factors and depressive symptoms might explain why many studies find conflicting results related to

causal relationships between such factors and depression (as discussed in further detail in Chapter 3).

As discussed above, a purely biomedical understanding of depressive disorders would encourage primarily pharmacological treatment, and a cognitive understanding would encourage primarily cognitive treatments for individuals with depression. A biopsychosocial understanding of depression, however, would take biological, psychological, and social aspects of the condition into account for treatment. For example, a biopsychosocial approach to treatment for depression might require that an individual engage in cognitive therapies, while taking medication for their condition, along with an adjustment in the social factors that might be influencing depression.

1.2.2 Contextualising depression

Predictions have been made about depression becoming the leading cause of disease burden in developed countries by 2030 (Mathers & Loncar, 2006). However, it is difficult to estimate the prevalence and incidence of depression for two reasons.

First, the number of depressed individuals differs greatly by region. A study by Simon, Goldberg, Von Korff and Üstün (2002) found, for example, a low prevalence of depressive symptoms in Nagasaki and Shanghai, medium prevalence in Berlin, Seattle, Ankara, Paris, and Manchester, and high prevalence in Rio de Janeiro and Santiago. The sociocultural and linguistic differences between populations in each of these regions are large, and so it may be difficult to compare such diverse data. Cross-cultural research on depression has found differences in the symptom types that members of particular cultures are likely to endorse. For example, positive feelings and the ideal of enjoying life are salient features of North American culture, whereas Japanese culture may inhibit the expression of positive affect (Iwata & Buka, 2002). Due to such differences in the manifestation of affect across cultures, factors such as stigma against

the presentation of negative affect may impact upon rates of diagnosis of depression. Thus, it may be difficult to compare the prevalence of depression across different countries and cultures.

Second, diagnoses of depression are thought to represent only a portion of cases of depression (Cochran & Rabinowitz, 2003; Kilmartin, 2005). This is partially because stigma may impact upon those with depression in particular groups (such as men) and depression may remain undiagnosed and untreated. Kilmartin (2005) suggests that men's greater likelihood to engage in suicide and to commit violent crimes, and abuse alcohol and drugs is evidence for undiagnosed depression. Nonetheless, reports from various agencies and organizations have indicated that approximately 4% of the population of several 'developed' countries experience depression each year (Australian Bureau of Statistics, 2008; Mood Disorders Society of Canada, 2009; National Health Service UK, 2010). In Australia, more than 650,000 people between the ages of 16 and 85 were diagnosed (according to diagnostic criteria) with a depressive episode in 2007 (Australian Bureau of Statistics, 2008). As there are only statistics for diagnosed cases of depression, it may be more apt to say that depression seems to impact upon *at least* 4% of the population and possibly significantly more.

Gendered perspectives of depression

As statistics relating to depression are usually taken from diagnosed cases of depression, it is relevant here to consider some of the ways that gender intersects with depression. In addition to stigma, as mentioned above, gender norms may be a factor influencing whether men with depression will be diagnosed, causing some to question the validity of current estimates of instances of depression in men (Kilmartin, 2005). For example, many men are thought to suffer from undiagnosed depression because men are reportedly less likely than women to seek help (Glise, Ahlborg, & Jonsdottir,

2012), and health professionals may be less likely to diagnose depression in men (Rieker & Bird, 2005).

The burden of depression impacts upon men in several ways. For instance, depression influences occupational and economic aspects of life, and can have implications for lived social experiences of those affected (Degney et al., 2012). More specifically, Degney and colleagues found that men might encounter difficulties with responsibilities at work, and a lack of social support. Work responsibilities and social support issues are not specific to men, but despite greater equality between genders in recent decades, work responsibilities are still often thought of as part of a man's identity, and women more often report greater social networks and social support than men (Thompson & Walker, 2013). Thus popular understandings of gender and gendered norms may influence the relationships between employment and depression, and social support and depression.

The relationships between depression and male gender are complex and currently not well understood (Van de Velde, Bracke, & Levecque, 2010). Hence, a greater research focus on men's depressive experience is warranted to begin to unpack and understand the experiences of depression from men's perspectives.

Men are less likely to receive a diagnosis of depression than women (Nolen-Hoeksema, 1987). Specific gender differences in the prevalence of depression seem complex and not yet well understood. Evidence does suggest greater prevalence, incidence and morbidity risk of depressive disorders for females than for males (Addis et al., 2010; Piccinelli & Wilkinson, 2000). Piccinelli and Wilkinson's (2000) critical review of gender differences in depression suggest several reasons for such differences. They suggest that females may be more likely than males to experience traumatic events at young ages (such as, but not only, sexual abuse), and that there are particular gender-specific stresses (including marriage, childbearing, and a potential

corresponding lack of opportunities) that may impact females more than males.

Piccinelli and Wilkinson (2000) also suggest that even though females may have more and stronger social supports than males, these could also be risk factors for increased incidence of depressive disorders should they lead to females being more vulnerable to events impacting upon those around them.

This difference in the rate of depression diagnosis by gender appears to emerge after childhood (Nolen-Hoeksema & Girgus, 1994). A potential reason for this is that gender identity becomes more salient as individuals enter adolescence. Indeed, men who highly conform to gender ideologies and gender norms have been suggested to be less likely to be endowed with positive help-seeking attitudes (Addis et al., 2010). Thus, as boys develop ideologies of masculinity, they may be less likely to discuss problems, potentially contributing to the lower rates of depression diagnosis in adolescent males when compared with females of the same age.

Indeed, knowledge about gender norms is gained throughout children's elementary years (Blakemore, 2003). Norms about gender roles might include behaviours that are stereotypically ascribed to one particular gender such as performance of appearance, personality attributes, preferences, and activities (Deaux & Kite, 1993). Norms about gender roles can change over time, as is evident in the mid-20th century when many women entered previously male-dominated roles (Diekman & Goodfriend, 2006). Nonetheless, men still appear to be socialised in such a way that they are expected to neither dwell on nor express negative emotions (Davidson-Katz, 1991). In contrast, women are expected to express their emotions, and medical institutions have positioned seeking help for health problems as a feminised pursuit (Johnson, Oliffe, Kelly, Galdas, & Ogradniczuk, 2012). Gender norms, therefore, are likely to impact on men's subjectivities of depression.

Depression – as a problem impacting upon one’s emotionality – and seeking help for depression are both socially feminised. Discourses about depression as a gendered condition are widespread. Some pharmaceutical advertisements for depression medication have been criticised for reproducing normative feminised discourses about how ‘being female’ and multi-tasking – often a socially feminised activity in itself – might be linked to depression via hormonal changes (Gardner, 2007). At the same time, Gardner (2007) suggests that advertisements for antidepressants that are aimed at men similarly reproduce normative discourses of gender. These advertisements emphasise that depression is an illness of the brain with unknown causes and triggers, and thus may be thought to appeal to the stereotype that men want to think of their depression as having a biological basis that can be ‘fixed’ with medicine. It may be useful to move towards representations of depression that are sensitive to nuances of gender, and to individuals’ multiple subjectivities.

Assumptions about men and depression

Research has long debated the validity of and reasons for sex differences in depression (Nolen-Hoeksema, 1987). Although outward manifestations of depression do appear to differ by gender – with men reportedly tending to find it easier to talk about physical distress but more difficult to talk about emotional distress than women (Danielsson & Johansson, 2005) – the experience of depression appears to be similar for men as it is for women (Addis, 2008). Addis (2008) argues that research comparing the experiences of depression in men and in women from the outset risks artificially inflating the differences between the two. Comparisons about differences in men’s and women’s depressive experiences could be made after a greater body of knowledge has been developed, if necessary.

Engaging in research specifically on men's depression does risk reifying men as 'the problem' in relation to depression. To assume that all or even most men experience depression in a uniform way would oversimplify the issue. Depression in men – as in anybody – is experienced in relation to the social context of daily lives. Two relevant contexts in which men may experience depression include a) being a man, and b) actively reproducing masculine patterns of health behaviour. These patterns of behaviour are what Verdonk, Seesing and De Rijk (2010) might call 'doing' masculinity by not doing health. This refers to how choosing not to engage in health behaviours may reproduce norms of masculinity. Such ways of enacting health behaviours, then, can be thought of as means for the construction, or reproduction, of masculinities. Connell's (2012) writing would suggest that these health behaviours are collective patterns of being rather than expressions of gendered traits. However, individual men may enact such behaviours. Therefore, in my dissertation, I aim to be careful not to suggest that men's depression is a product of masculinity, but that men's experiences of depression may shape and be shaped by issues of gender.

I acknowledge that factors other than 'doing masculinity' are likely to impact upon men's subjectivities of depression including age, socioeconomic position, educational and occupational status, community memberships, or even personal experience with trauma. Men are multi-dimensional beings (Nash, 2012; Rosenfield, 2012). There are, however, demonstrable links between gender contexts and mental health behaviours (Lyons, 2009). A focus on only one aspect of an individual's identity (e.g. being a man) ignores the multifaceted nature of the individual. Indeed, Connell & Messerschmidt (2005) emphasise that masculinity is not something fixed or naturally part of the body. Rather, they argue that masculinity encompasses ways of being and acting in social action. It follows, then, that there are multiple ways to define

masculinity as it intersects with multiple factors including culture and class, as well as local social relations.

Research that assumes that being a man is the facet of identity that is significant to men may risk over-interpreting that status as a problem. A focus on masculinity is warranted, however, because health behaviour is one site where norms of gender are produced (Lyons, 2009). Therefore, throughout my research, I have not assumed that gender is the only factor important to men in their subjectivities of depression, but that it is part of the context in which men experience depression.

Summary

This section has discussed how depression has been historically defined in terms of diagnostic criteria and that these criteria (along with the self-report measures of depression) may be potentially problematic. Specifically, problems may arise from the interaction between stigma and diagnostic criteria. Depression may actually be underdiagnosed due to the stigma attached to mental health concerns and symptoms. In the next section, I will discuss men's health more broadly, and explore some of the ways that this stigma may impact upon men and their mental health.

1.3 Men's Health

This section provides a broader context of the existing literature in regards to men's depression and its place in the men's health story. Men's health research and practice has traditionally focused on physical health issues. According to Malcher (2006), this focus has most often been concerned with matters of sexual health – with governments typically restricting funding for support of men's health to that of the prostate and sexual organs. However, emerging research and policies are beginning to treat men's health as more than simply men's sexual health.

Underpinning Australia's 2010 National Male Health Policy is an emphasis on not just physical aspects of health, but also mental and social wellbeing (Department of Health and Ageing, 2010). In terms of mental health specifically, the policy acknowledges the greater risk of depression in males dealing with changes in work, or dealing with relationship breakdown. The policy is less clear on how action can be taken to realise better mental health outcomes for men – stating that “governments[,] health service providers [and] peak health organisations” should take action to develop and deliver initiatives and services for these men (Department of Health and Ageing, 2010, p. 19).

Ireland's 2008-2013 National Men's Health Policy (Richardson & Carroll, 2008) provides another example of contemporary policies about men's health, but it also offers more suggestions about how action could be taken to realise the importance of the holistic nature of men's health. Amongst other recommendations, it suggests that strategies to reduce stigma surrounding 'taboo' subjects like depression should be implemented not only in health information services and programmes, but also in marketing and media publications.

On an international public health level, the World Health Organization's (2002) gender policy aims to discontinue health inequality between men and women and to contribute to better health for all genders. To this end, the policy reinforces the importance of “gender-responsive planning, implementation and evaluation of policies, programmes, and projects” (World Health Organization, 2002, p. 2). The World Health Organization uses this policy to support member states to work towards more equitable health outcomes for members of all genders. From 2002, the Gender, Women and Health arm of the World Health Organization have released newer publications, but only two relate specifically to men and boys (World Health Organization, 2014). In

spite of the heightened attention on gender equality in health– even at the international level – there remain several barriers to men’s access of health service.

Stigma is one such barrier to men’s health service access (Lyons, 2009). Stigma can be conceptualised as labelling, separation, and stereotyping of particular groups. Status loss and discrimination are two potential outcomes of stigma (Link & Phelan, 2012). There are at least two levels on which stigma operates (Corrigan, 2004). On a broad level, prejudice against a stigmatised group can become socially endorsed. On a private level, individuals can internalise publically endorsed prejudice. In terms of masculinity and stigma, masculine norms typically stigmatise men who are unhealthy, and further stigmatise men who seek help for health (Addis et al., 2010). Aromaa and colleagues (2011) argue that stigma is a barrier that stops many men from health help-seeking, but than men who are concerned about their condition enough will engage with health services.

To look at how men deal with stigma and engage with help-seeking, research attention has been given to men’s interactions with health services (Harris & Mckenzie, 2006; Malcher, 2006), and suggestions offered for improved practice for professionals and policy makers. For better health outcomes for men, health systems need to be better tailored to meet men’s needs (Smith, Braunack-Mayer, & Wittert, 2006). Health professionals with competencies valued by men – including a ‘frank approach’, demonstrable competence, thoughtful humour usage, empathy, and prompt health issue resolution – are likely to communicate with men in useful ways, improving men’s health care outcomes and, potentially, increasing their future help-seeking (Smith, Braunack-Mayer, Wittert, & Warin, 2008a). As far as mental health is concerned, normative gender patterns may conceal men’s expressions of depression. For example, Danielsson and Johansson (2005) found that when compared to women, men appear to call more attention to their physical symptoms of depression, and to have a smaller

vocabulary of terms to communicate their depression. Thus when talking to others, men might draw upon physical symptoms more and have fewer repertoires to talk about depression, which could potentially lead to a greater likelihood that depression will remain concealed. Therefore, avoiding normative gender assumptions in medical and health service practice may lead to better outcomes for patients of health professionals.

1.3.1 Men's mental health

Women's mental health has generally attracted greater research and clinical interest than men's mental health. Riska (2009) argues that through the times of early psychiatry, men's mental health concerns were less often problematised than women's. As research and practice in mental health has had a strong focus on women (Sabo, 1999), understandings of men's mental health have not been as well developed. Writers have critiqued the focus on women's mental health as problematic for women in several ways (Sabo, 1999), but the focus may be problematic for men as well. For example, Brooks (2010) points to the disproportionate distribution of psychological diagnoses among men and women to suggest that criteria for mental disorders are sensitive to gender. For instance, women are diagnosed twice as often as men with anxiety and panic, and nine times as often with eating disorders (Brooks, 2010). However, the psychology of men is beginning to gain attention in clinical and research settings, and is becoming increasingly visible within daily life (Addis & Cohane, 2005). Men continue, however, to underutilise health services for mental health problems when compared with women, hence the greater need to give attention to men's mental health and mental health help-seeking behaviours (Addis & Mahalik, 2003).

Despite an underuse in mental health services, men more often engage in behaviours that may lead to or be caused by mental health problems, including violence, sexual assault, and substance misuse (Brooks, 2010). For example, violent behaviour

may be a result of personality disorder, and may also lead to posttraumatic stress disorder. Furthermore, behaviours such as violence, sexual assault, and substance use are culturally sanctioned as features of masculinity (Addis, 2008). Adding to the complexity of the issue, violence and substance abuse may be tools men use to ‘mask’ their mental health problems (Addis & Cohane, 2005)

Men are also said to be less likely to be communicative about their mental health problems (Addis, 2008). Not only are they less likely to talk about issues, they also tend to have smaller social circles and less social support than women (Bates & Taylor, 2012). Thus men who are isolated geographically or socially may particularly need support in order to minimise mental health problems (Hewitt, Turrell, & Giskes, 2012).

Men with depression

As with mental health more generally, depression research has predominantly focused on women and their experience of depression (Addis, 2008). This may be because depression has a long history of being associated with women (Ussher, 2010). Women are more often diagnosed with depression and the biomedical model has been used to associate this greater likelihood of diagnosis with women’s reproductive hormones causing greater emotional distress – an explanation that has been critiqued by feminist researchers (Seaman, 1997; Studd, 1997). Gendered biases are built in to the psychometric instruments used to diagnose and classify depression – pathologising aspects of supposedly feminine behaviour that could alternatively be viewed as normative in some contexts (such as loss of libido or crying) (Salokangas, Vaahtera, Pacriev, Sohlman, & Lehtinen, 2002). Furthermore, medical practitioners are also more likely to diagnose a woman with depression due to gendered stereotypes about the condition (Sherman, 1980) as, for physicians, depression may be a more salient disorder in women than in men. Women may also be more likely to explain their suffering as

depression because it may be a more culturally-available explanation at times for women (such as in post-natal situations or coming through a divorce) to position themselves as depressed than it is for men (Ussher, 2010). These biases may be problematic for both men and women.

Indeed, research has focused predominantly on women's experiences with depression perhaps because the symptoms of depression are socially feminised and because medicine has pathologised femininity through history (Ussher, 2010). The men's studies movement has caused researchers to reflect on the lack of knowledge in several important areas of men's health (Riska & Ettore, 1999). This has resulted in an emerging body of research dealing specifically with men in relation to depression and distress. Nonetheless, there are still many gaps in understandings of depression as it impacts men in different ages and social groups. For instance, it has been noted that much of the research in the area has focused on middle-aged men (Oliffe, Galdas, Han & Kelly, 2012). As I discuss below in Section 1.4, one of my aims in this research is to contribute towards this growing field.

Brownhill, Wilhelm, Barclay, and Schmied (2005) argue that men are more likely than women to adopt maladaptive behaviour in response to depression, ranging from internalising behaviour such as avoidance, to externalising behaviour such as active violence or suicide. These behavioural strategies of managing and masking negative affect, consequently render depression in men more difficult for health professionals to identify (Lyons & Janca, 2009). Indeed, displaying emotions and health help-seeking are both culturally feminised (Branney & White, 2008). Thus, controlling and being silent about negative affect is one way of 'doing masculinity' (O'Brien, Hart, & Hunt, 2007). It may be preferable for a man to mask his depression (potentially turning to violence or suicide), rather than to risk a loss of masculine identity due to

seeking help for negative affect. Therefore men may not see other men going through depression.

Men who do not see other men experiencing depression may continue to think of depression as not 'normal' (Mahalik, 2008). Oliffe et al. (2012) suggest that there may be a limited number of archetypes of depressed men, and highlight three ways in which men with depression are often seen: as angry, as solitary, or as risk-taking. Thus men may not have access to positive role models when dealing with emotional distress. In this context, mass media (which may increasingly include social media) is one site where dominant constructions of masculinity may be challenged or reproduced (potentially marginalising or normalising help-seeking in men) (Anderson & Kian, 2012). Furthermore, media representations of health have become integrated into our everyday understandings, experiences and activities (Halkier, 2010). Research has found that men are dominantly portrayed in media as inexpressive (Bengs, Johansson, Danielsson, Lehti, & Hammarström, 2008), less focused on relationships and more frequently involved with violence (Clarke & Van Amerom, 2008), and that the difference between 'most men' and men with depression is often exaggerated in portrayals of depressed men (Clarke, 2009). Lyons (2000) has argued that media representations of individuals with a given condition potentially influence how such individuals are perceived by both themselves and others. Thus media portrayals of men with depression may serve to reproduce or challenge the stigma of depression, and impact upon how men's depression is seen by others, and how men's subjectivities of depression are formed.

Not all recent portrayals of men's health in the media have depicted masculinity in crisis. It appears that cultural shifts in the kinds of masculinity celebrated by society are starting to make space for 'softer' masculinities to be enacted (Anderson & Kian, 2012; Kian & Anderson, 2009). Anderson and Kian (2012) drew on major newspapers

and Internet sites from across the USA to analyse sports news media. Findings from their analysis suggested that sports reporting appears to be changing and now portrays health and wellbeing as more important than always having to be considered a 'masculine warrior' in sport. Whether 'softer' masculinities are being portrayed in terms of mental illness and mental health help-seeking remains to be researched.

Indeed, and perhaps because of, the added stigma of mental health issues, recent media stories of men experiencing depression suggest that men may still hide their depression. This has been evident in several Australian media articles in which men have 'come out' as depressed. For instance, cricketer Michael Slater, a celebrated Australian sportsman, has talked about his reluctance to be involved with or show support for mental illness after being diagnosed with bipolar disorder, because he was concerned about implications it may have for his career (Slater, 2005). Another example is Australian Member of Parliament, Mr Andrew Robb, who only 'admitted' his depression after decades of dealing with the condition (Michelmore, 2012). More recently, in November 2012, Australian swimming champion Ian Thorpe released an autobiography in which he 'opened up' about depression. Prior to this, he had never revealed his condition to the public or even his own family (Australian Associated Press, 2012). Evidently, depression is still often seen as something to keep hidden – even from one's family – and to be concerned about in terms of its impact on career, for example.

Although gender norms may be problematic, recent research that has explored masculinity and depression suggests that masculinity may also bring about positive outcomes for men with depression. For instance, some participants in a study by Tang, Olliffe, Galdas, Phinney, and Han (2014) recast help-seeking for mental health concerns as an act of strength (an ideal of masculinity). Similarly, in a study exploring men's talk of suicide actions, some participants recast communicating with and confiding in others

as a means to self-management (also an ideal of masculinity) (Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012). Such findings highlight that it is important to note that masculinity can have potential positive impacts on men's experiences of mental distress.

Subjectivities of depression

I use the term subjectivity in the same way as Weedon (1987): to refer to an individual's conscious and unconscious perspectives, ideas, and feelings. Subjectivities are the products of sociocultural and historical contexts in which we are situated (Weedon, 1987). Language constructs subjectivities, and an analysis of language is one way in which we can view subjectivities (Gavey, 1989). Throughout this dissertation, I use the term 'men's subjectivities of depression' to refer to the range of understandings, perspectives, thoughts and orientations men develop towards depression. I particularly focus on the constitutive nature of language in the formation of these subjectivities. The poststructuralist approach I take (discussed in section 1.4 below) makes it possible to analyse multiple complex subjectivities of an individual, rather than focus on a single perception of reality.

Few studies have looked at how men make sense of their depression. Scholars have found that depressed individuals (regardless of gender) may find their condition difficult to understand due to the complexity of the condition (Kokanovic et al., 2012). Using metaphors to describe depression is one way depressed individuals have been reported to be able to explain and make sense of their condition (Charteris-Black, 2012). Some of these metaphors likened depression to a descent, to weight or pressure, or to darkness. Metaphors may have application in therapeutic settings as an interpretative framework. Indeed, use of metaphor in therapy provides the opportunity for individuals to reinterpret their depression, potentially with therapeutic effects

(Burns, 2007). Charteris-Black (2012) found that although the types and frequency of metaphors were the same for men and women, men were less likely than women to mix metaphors and cluster metaphors together in their talk of depression. This finding is notable because a smaller repertoire for mixing metaphors may inhibit an individual's ability to reinterpret their discourses (Charteris-Black, 2012). Indeed, Alasuutari and Järvi (2012) note that reinterpretation of discourses of depression may provide depressed individuals with a sense of agency over their condition. Their study was concerned with children's talk about their parents' mental disorder and found that children could draw on particular discourses in order to position themselves as knowledgeable and agentic. For example, drawing on an empirical vocabulary gave children the ability to describe the observable events of depression, whereas drawing on medicalised vocabulary had stigmatising implications and hindered children's communication about depression (Alasuutari & Järvi, 2012). Thus research into discourses of depression is important as the linguistic repertoires we use in relation to depression contextualise and situate depressed individuals in particular ways.

In Galasiński's (2008) work about men's discourses of depression, he discusses how men were generally not engaged with the medical model of depression in their talk about their condition. To his depressed informants, the social experience of depression (the way that depression limited how participants interacted with the world around them) was more relevant than the symptoms of the condition (the way depression made them feel directly psychologically or physically). In terms of masculinity, Galasiński (2008) suggests that gender expectations are at least in part responsible for men's uneasy subjectivities of depression. Participants in his research were found to use strategies including impersonal pronouns, and referring to their depression from an outsider's perspective to retain masculine subject positionings while discussing their condition.

1.4 Overview and Aims

In this section I will provide a summary of the key points of literature reviewed in this chapter, stating the rationale for my research. I will also explain the positions that I am taking in relation to the relevant issues that have been discussed thus far.

This chapter has explored how the conceptualisation of depression originally emerged from a biomedical perspective, but that such a perspective may be limited. This is because health professionals can have difficulty dealing with both biomedical and personal contexts of depression (Thomas-MacLean & Stoppard, 2004). Furthermore, biopsychosocial models of depression posit that any number of biological, social and psychological factors interact with one another to influence mental health outcomes (Gilbert, 2001). Better understandings of these personal, psychological, and social contexts of depression may benefit patients. Thus an aim of this dissertation is to build better understandings of such contexts of depression.

I have discussed also how policies have been emerging that deal specifically with men's health, such as that by the Department of Health and Ageing (2010). This is a good development given that men's health policies are relatively new. One concern about such policies at this stage is that they seem to suggest that healthcare needs to recognise the importance of mental and social wellbeing in men (Department of Health and Ageing, 2010), but they do not yet provide suggestions for specific actions for how this should be done. Another aim of this dissertation, therefore, is to provide insights into men's subjectivities of mental distress that may help to inform the direction of future policies and practice.

Depression has long been seen as a women's issue (Ussher, 2010). A large body of research has contributed understandings of women's experiences of depression (Addis, 2008; Galasiński, 2008). I uphold that such research into women's experiences of depression is important, and do not intend to discount the significant contributions

this research has made. However, another aim of my research is to redress this balance and undertake research to contribute to our understandings of men's experiences of depression. Thus the research findings presented in this thesis are intended to make no supposition about the nature of depression in women, or even the nature of depression in men in contrast to women. The findings are limited only to depression as it pertains to men, which is not to say that they will not share relevancy or implications with that of women. It is not an intention of the research presented in this dissertation to draw conclusions about the differences between men and women.

In terms of understandings of men's experiences of depression, I have also discussed in this chapter how there are taken-for-granted assumptions about men in relation to mental health. For example, men are assumed not to want or seek help for depression. Galasiński (2008) suggests that there may actually be ways in which men are 'doing' health well, and that some of our assumptions about men not wanting or seeking help, or dealing poorly with depression may be problematic. Thus a further aim of this dissertation is to explore some of the ways in which men may be doing health well through an increased awareness of men's subjectivities of depression.

To realise these aims, this dissertation has three overarching objectives. The first of these objectives is to explore the research conducted in the area of men's depression by performing a systematic review of prospective cohort studies that explore the development of men's depressive symptoms. The second objective is to investigate how depression in men is commonly portrayed and culturally understood, by exploring news media constructions of men's communication about depression. The final overarching objective of this dissertation is to explore men's perspectives, ideas, and feelings about depression. Specifically, I aim to add to the understandings of men's subjectivities about depression.

In order to enrich current understandings of men's subjectivities of depression, I approach this research with a poststructuralist framework (which I discuss in greater detail in Section 2.1). This perspective considers reality to be socially constructed, and conceptualises knowledge as contextual and historical (Nettleton, 1995). In a poststructuralist stance, an individual is not assumed to have a single essential subjectivity (Gavey, 1989). This approach is opposed to an emphasis on objective perceptions of reality (Weedon, 1997). As such, poststructuralism does not consider just one account of knowledge as the only correct way of understanding the world. Instead, it holds that there are multiple ways of understanding our realities.

1.4.1 Outline of dissertation structure

The current research will be presented in the form of a 'thesis by publication' format, as prescribed in the guidelines of The University of Adelaide's Graduate Centre. The three analytic chapters in this dissertation are manuscripts I have authored throughout my research candidature. The outline of the dissertation structure is as follows:

Chapter 1 (the current chapter)

This chapter has introduced the research carried out for this thesis and discussed the research context. It has provided some discussion on models of causation, the rationale for the research, and explored contexts of depression and masculinity in academic and broader understandings.

Chapter 2

In the second chapter, I discuss the data and analytic methods used for the research presented in later chapters, as well as the theoretical orientation of my research.

This is followed by an overview of implications of the study for theory as well as for health practitioners, public health, and health policy.

Chapter 3

The third chapter presents the first research manuscript prepared for this dissertation. The manuscript is entitled “Development of Men’s Depressive Symptoms: A Systematic Review of Prospective Cohort Studies”. It is published in the Journal of Men’s Health, and presents a systematic review of longitudinal cohort studies that focus on factors associated with depressive symptoms in men.

Chapter 4

Chapter 4 presents the second research manuscript prepared for this dissertation. The manuscript is entitled “‘We’ve Got to Break Down the Shame’: Portrayals of Men’s Depression”. It has been accepted for publication and is currently in press in Qualitative Health Research, and presents a discursive analytic critique of news media portrayals of men engaging in communication about their depression.

Chapter 5

In chapter 5, I present the third and final manuscript comprising this dissertation. The manuscript is entitled “‘Male’s don’t wanna bring up anything to their doctor’: Men’s subjectivities of mental health” and has been prepared in publication style. It presents a thematic analysis of men’s experiences of depression as a biomedical and social problem.

Chapter 6

In the final chapter, I revisit the research objectives of the thesis in regards to each research article included in the dissertation. I summarise and discuss the research findings of the dissertation, and elaborate on the overall contributions made in terms of theory and practice. I conclude with a discussion of the limitations and strengths of this dissertation, and propose directions for future research.

Chapter 2

Methodological Considerations

2.1 Chapter Overview

This chapter is concerned with the methodological and theoretical background to the research in this dissertation. I first discuss the data collection and analysis for each of the three studies presented here. Then, I explain the theoretical underpinnings of the research. Where relevant throughout this chapter, I discuss the potential problems and concerns that I had anticipated prior to commencement of the overall research project. I do so in order to practice reflexivity – “the project of examining how the researcher and the intersubjective elements impact on and transform research” (Finlay, 2003, p.4). I will return to some of these points in my discussion in Chapter 6.

2.2 Theoretical Orientation

As mentioned in Chapter 1, the current research is anchored by a poststructuralist view – a framework whereby no single account of knowledge is considered as ‘right’. Weedon (1997) discusses some of the underpinning principles of poststructuralism. One of these principles is a critical stance to what are generally taken-for granted understandings of the world. To maintain a critical stance throughout my research, I aimed to avoid assumptions about men and depression. Such assumptions include the often taken-for-granted notion that men and women are inherently different, or the suggestion that men will not talk about their depression because they do not want to discuss issues about emotions or feelings.

Another principle of poststructuralism is that understandings of the world are situated in a given sociocultural and historic background. Thus although I am critical of

the assumption that men are somehow different to women in their experiences of mental health, I also understand that mental health has been historically and culturally constructed in gendered ways, potentially leading to differences in the expression of depression in men as compared with women. Another taken-for-granted assumption about depression is that it exists as a medical condition and that it can be diagnosed. Diagnosis and categorisation of someone as ‘depressed’ is a way of socially constructing the individual and the disorder (Brown, 1995).

The systematic review presented in this dissertation in Chapter 3 is a review of a large body of mostly positivist research. Positivism posits that the only valid knowledge is scientific knowledge (Laudan, 1996). Such a philosophy is in contrast with poststructuralism, which does not consider any one type of knowledge to be the only valid knowledge. Although the systematic review study reviews positivist literature, I suggest it is not incompatible with the poststructuralist framework of this dissertation – as poststructuralism does not consider scientific knowledge invalid, but rather considers it one of many types of valid knowledge. Indeed, the major findings from the mostly positivist literature in the area informed the analysis in subsequent studies in Chapters 4 and 5.

In undertaking research about men’s experiences of depression, it is not my intention to unquestioningly reproduce gendered patterns of health in this dissertation. Stereotypical norms of gender are often taken for granted and indeed hard to avoid in social interaction (Johansson, Bengs, Danielsson, Lehti, & Hammarström, 2009). As discussed in Chapter 1, depression has been socially constructed as a gendered condition – with women being more often assumed to ‘suffer’ depression (Galasiński, 2008). My research also, inevitably, constructs particular versions of masculinity and of mental health and depression, thus it is important to discuss my orientations to this issue. In this dissertation, I do not intend to discount the important work focusing on

women's experiences with depression, nor do I wish to suggest that depression in men is qualitatively more difficult, dangerous, or damaging than it is in women. Taking men as a focus of research is in part motivated by a severe gap in research about men in depression (Addis, 2008). This dissertation, along with other emerging work in the field, is one attempt to redress the relative lack of research with a focus on men's experiences of mental health concerns. Thus although this dissertation is limited only to the experiences of men in relation to depression, it has still been informed by, engages with, and remains relevant to the significant body of research on women's experiences of depression.

In Chapter 1, I discussed the biomedical model of depression and the way in which it may be considered a dominant understanding of depression. In drawing on the concept of depression, however, it seems impossible to avoid the biomedicalised understanding of depression as a disease. Not only is the biomedical discourse of depression readily available to laypeople (Lafrance, 2007), medicine is seen as the authority on what constitutes illness (Nettleton, 1995). Thus, the current research inevitably also draws on biomedical understandings of depression. The first study presents a systematic review of longitudinal prospective cohort studies that have assessed depression in terms of diagnostic criteria (American Psychiatric Association, 2000; World Health Organization, 1992) or depressive symptom inventories (Beck et al., 1988; Radloff, 1977) – both of which are rooted in biomedicine. The third study looks at the discourses of men whose depressive symptoms have been assessed with the Beck Depression Inventory (BDI) (Beck et al., 1988). However, although I acknowledge the biomedical roots of these definitions of depression, the focus throughout is more concerned with the lived experiences of men with depression (through an exploration of the factors associated with depression in the systematic review, the ways in which news media portrays men with depression in the media

analysis study, and the ways men talk about their experiences with depression in the interview study). In order to take into account these multiple sources of knowledge, I take a poststructuralist view to examine the phenomenon we label as ‘depression’.

2.3 Data Collection and Analysis

I now turn to discuss some more specific details of the data collection and analysis conducted for the research presented in this dissertation. Each study I conducted for this dissertation uses different data sets and data analytic frameworks to report on the experience of men’s depression. The data comprise of published longitudinal cohort studies on depression in men, Australian news media articles reporting on men with depression and men’s communication of their depression, and individual interviews with men who had experienced multiple depressive symptoms. Descriptions of each data source are provided in the research article chapters within this dissertation. In this section, I will provide an overview of the approach to data collection overall and analytic techniques used.

This dissertation explores different understandings of and assumptions about men with depression from three perspectives: 1) the perspective of published research, 2) the perspective of media portrayals, and 3) from the constructions of depression produced through the discourses of depressed men. In this dissertation, I will present each of these studies as standalone research papers. In the concluding chapter, however, I aim to discuss the findings of the studies in relation to each other. I have chosen to research these three broad areas of men’s depression in order to triangulate the findings of each data set. Triangulation of diverse data sets and research methods allows for a thorough exploration of the phenomenon in question (Maggs-Rapport, 2000) – specifically in this dissertation, men’s depression. Through this triangulation, I am

concerned with exploring the differences and similarities in understandings of depression, and with considering the implications of various constructions.

Triangulation could be thought to be a somewhat positivistic approach. This is because it is sometimes referred to as a way to find a single truth about a phenomenon (Maggs-Rapport, 2000). However, as I take a post-structural perspective with my research, I see this triangulation as less of a means to understand the ‘truth’ about depression. Instead, I see triangulation as a way of discussing multiple truths, with potential for comparing, contrasting, and critiquing these truths. I suggest that no one source of data (published research, news media, and men’s accounts in my dissertation research) is more valid than the other, but that a greater understanding of each of these will enrich knowledge about men’s depression in a much broader sense.

Through considering the findings of each of the studies within this dissertation, there appeared to be a common theme related to primacy of the biomedical model of depression. This is expanded upon in greater detail in Chapter 6. Triangulation of multiple approaches to multiple data sets allows for discussion about the way the primacy of the biomedical model impacts each aspect of the problem (published scientific research, news media portrayals, and men’s narratives of their experiences).

2.3.1 Systematic review

The first study (reported in Chapter 3) was conceived as a broad overview of factors related to depression in adult men, in order to contextualise the thesis as a whole. In terms of the scientific literature, the number of research articles published that focus on women’s depression significantly outnumber those that focus on men’s depression (Addis, 2008). Despite this disparity in research attention, men more often suicide, and more often receive diagnoses of alcohol or drug dependence (Cleary, 1997). This was part of the rationale for examining current understandings of

depression as a biomedical condition and for considering which factors have been reported to impact upon change in or incidence of depression in men. As such, my research question for this study was “what factors are currently understood to impact upon change in or incidence of depressive symptoms in men?” I decided that a systematic review approach would be appropriate for this question, as it would allow me to examine research of a high level of evidence in a comprehensive manner. Furthermore, a systematic review methodology allows an exploration into the consistency, generalisability and variability of scientific findings (Mulrow, 1994). A comprehensive review of the literature also prevents the researcher from reproducing research that has already been conducted through an in-depth familiarisation with relevant research in the area (Mulrow, 1994). It was thus an appropriate first step in my research overall, helping to inform the design and focus of the subsequent studies.

After choosing a systematic style of review, decisions need to be made about the type of studies to be included, the kind of participants on which to focus, where to source studies for inclusion, and how to synthesise the results. First, I decided that observational studies would be the most appropriate studies to include in the review. Observational studies are considered to be of a lower level of evidence than randomised controlled trials (Barton, 2000; Concato, Shah, & Horwitz, 2000). For the purposes of my review question, however, observational studies were the most appropriate, as I was interested in an outcome of incidence of, or change in, depressive symptoms. Due to ethical issues, randomised controlled trials would not easily be able to explore antecedents of depressive symptom change.

Second, as the focus of my review was on men’s depressive symptoms, I decided that studies should be included only if depressive symptoms of males over the age of 18 were an outcome variable. I chose not to include studies where the outcome measured was depressive symptoms in males of younger ages because children and

adolescents have very different social, economic, developmental and organisational contexts within their lives when compared with adults. Thus, the inclusion of studies on depressive symptoms in younger populations could introduce greater variability in outcomes to the review. Studies that had included women as participants were not necessarily excluded from the systematic review, provided that the study reported outcomes for men separately to those of women.

My third consideration in developing the systematic review protocol was to ensure that I was sourcing all relevant published articles. The first part of this process involved the searching of databases for articles for inclusion. I searched the Medline, PsycINFO and Scopus databases – choosing three comprehensive databases most likely to store relevant research. In addition to these research databases, I searched the Cochrane Library – a depository of systematic reviews – for other work of potential relevance to my review. The second part of the process was to search the reference list of all included studies to ensure that I identified as many studies for inclusion as possible.

The fourth consideration in undertaking this systematic review was to decide on the method of data synthesis to be used. This review was broad; the studies included were varied in terms of factors studied, measures used, populations sampled, and findings. Thus a statistical method of aggregation such as meta-analysis was not appropriate, and it was not the aim of the study to calculate or report any effect sizes. Rather, a narrative approach to systematic review was chosen. Narrative analysis is particularly useful when various study elements are not similar enough (Verbeek, Ruotsalainen, & Hoving, 2012), such as in this review. Rogers et al. (2009) suggest that approaches that use narrative synthesis in systematic review can be limited as they can offer only few insights into the moderators of statistical relationships. However, such an approach does have the benefit of offering a greater scope to discuss research

implications (Rogers et al., 2009). Within the context of my thesis as a whole, following a narrative approach to systematic review was also useful in generating research questions for my subsequent studies. More details about the exact steps involved in the systematic review are included in Chapter 3.

2.3.2 Discursive analysis of news media data

In focusing on the issue of men's depression, I became interested in how it was talked about publicly. From my systematic review (Chapter 3), it became clear that multiple biopsychosocial factors were associated with men's depression. Given that the media has been identified as important in the transmission of health messages and in the shaping of public understandings of health (Lyons, 2009), I speculated on how these biopsychosocial factors were portrayed in news media.

The data corpus for the study presented in Chapter 4 comprises Australian news media articles of men's depression published between 2007 and 2011. This period reflects an increase in the media coverage of depression due to public health initiatives such as Movember. Movember is now a worldwide event, which began in Australia and New Zealand but is now running in North America, South America, Africa, Asia, and Europe (Movember, 2012). Movember involves individuals growing moustaches during November each year to raise money and awareness for men's health issues, with a specific focus on prostate cancer, testicular cancer, and mental health issues (Movember, 2012).

I sourced all articles which appeared under the 'depression' subject heading from the Factiva database. Factiva is a resource that collects full text items from major newspapers, journals, magazines, and radio and television transcripts. Factiva is a database that places emphasis on comprehensive indexing for its articles in order to both reduce information overload and improve retrieval of relevant articles (Sykes,

2001); it is systematic and therefore useful for collating media data for analysis. Factiva employs 'Subject headings', which refers to standardised terms assigned to each article in order to describe the contents of the article. The word depression has many other meanings and thus a word search for 'depression' or 'depressive' alone returns many irrelevant items related to issues such as economic depression, geographic depression, or agricultural depression. The subject heading 'depression' refers only to psychological depression. This means that searching Factiva for all articles with the subject heading 'depression' will yield as many relevant articles as possible while minimising irrelevant articles. Such a search is therefore an appropriate tool for the research presented in Chapter 4.

One of the benefits of using news media as a data source is that it is naturally occurring. This is in contrast with data that are produced specifically for research. There are several advantages to the use of naturalistic data, including that the concerns of the researcher are secondary to the existence of the data, that insights beyond the initial research question can be explored, and that the topic is studied directly rather than through the researcher making inferences about data contrived for the research questions (Hugh-Jones & Gibson, 2012).

Using only Australian news media articles potentially limited the research context, as did only analysing news media articles from a five-year period. One benefit of sourcing news articles from the Factiva database is that it catalogues both major news media, and a range of regional and local news media sources. It became a strength of the study that I was able to include a diverse range of news media articles from within that five-year period in Australia.

I read each news media article collected (n=702) to assess which were relevant to men's or a man's experience of depression (during this process I discarded articles that did not report specifically on men or a man). I then followed thematic analytic

techniques to explore the broader patterns present in the newspaper articles. These techniques (discussed in greater detail in Chapter 4) allow for themes within data to be identified, analysed, and reported (Braun & Clarke, 2006). One of the major themes, and one that is relevant to theories of masculinity, within newspaper articles about men's depression was how men communicated about their experiences with the condition, and what communication meant for these men.

To focus particularly on this theme of communication about depression, I selected extracts of articles relevant to men's communication, and performed an analysis on these extracts informed by discursive psychological principles (Edwards & Potter, 1992; Potter, 1996)

The first of the principles underpinning discursive psychological analysis is that text or talk is our primary means of action (Potter, 2003). Discourse (operationalised as text or talk) is functional and constructive and thus an analysis of discourse is interested in what text or talk (or the producer of text or talk) 'does'. For instance, texts or talks perform activities such as explaining, blaming, and creating or reproducing categories. A discursive psychological approach is not concerned with the inner psychological processes behind why the speaker or writer of the text or talk has produced their accounts. Rather, such an approach gives attention to patterns of language use and the constructions they produce (Edwards & Potter, 1992). For example, in their analysis of men's health discourses, Verdonk and colleagues (2010) found that men's talk constructed the action (or inaction) of not taking care of their health as masculine. This was achieved, for instance, by talking about ways in which they were 'outsourcing' health care to female partners. Talking about health care as a women's concern is one way in which discourse can be seen as actively reproducing and constructing particular understandings of health and of gender.

The second principle is that discourse is situated. Potter (2003) argues that discourse can be situated in three ways. The first of these is a sequential situation and refers to how the text or talk is organised in a local context. The analyst would be interested in what comes before or after a particular part of text or talk. The second way in which discourse is situated is an institutional situation and refers to what institutions and tasks are relevant to a text or talk. In the case of analysing news media, it is important to be mindful of the institutional settings that produce a news media piece. Namely, these institutional settings include journalistic considerations such as media impact and saleability. The last type of discourse situation is rhetorical situation and refers to the historical and sociocultural setting in which discourse is framed (Potter, 2003). For example, discourses of men and depression are framed within historical and sociocultural understandings of what constitutes men, masculinity, mental health, and depression. As discourses are framed within these understandings, there are particular interpretative repertoires that we can draw upon in producing text or talk (Edley, 2001). This is not to say that we only ever write or say what has been said before, but that there are certain patterns that we reproduce and combine to produce discourse (Edley, 2001).

The third principle of discursive psychology is that discourse is both constructed and constructive (Potter, 2003). Discourse is constructed in that it is made up of several elements including words, common ideas, and categories. A discursive psychological approach may look at the types of words, ideas, and categories that are deployed in text or talk, in order to explore patterns of meaning. Discourse is constructive in that text and talk act to produce or challenge different versions of the world, actions, events and identities (Edley, 2001). A discursive psychological approach does not necessarily deny that individuals, illnesses, or other objects physically exist, but emphasises that the social meanings of existence are generated through language and communication. Thus in this research, I do not aim to treat men or depression as stable categories of gender or

health, respectively. Indeed, I will focus on how news media articles construct gendered and depressed identities through how men and depression are positioned in text.

I drew on these principles of discursive psychology because they have several potential advantages. These include the potential for researchers to be able to: a) explore both hidden and dominant discourses, b) to focus on potential alternative subject positions for individuals to use to reframe their experiences, and c) to lead to positive social change (Morgan, 2010). Furthermore, it has been argued that discourse analytic principles can be applied to all forms of discourse (text as well as talk) (Tannen, 1982), hence such an approach is appropriate for analysing the news media data.

Discursive research has already begun to enrich understandings of men's health and help-seeking behaviours. Seymour-Smith and colleagues (2002) analysed the discourses of health professionals in relation to men's access to health service. They found that their participants were ambivalent in their accounts of masculinity. On the one hand masculinity was suggested to be responsible for men not seeking help, but on the other hand it was seen as an amusing trait of men to enact masculinity and choose not to seek help for health concerns. In a study that looked at discussions about health in focus groups with men, O'Brien, Hunt, and Hart (2004) suggested that although some men did uphold dominantly masculine ideas about health and avoidance, other men would question or suggest alternatives to avoiding help-seeking. In a similar way, Galasiński's (2008) work on men's accounts of depression has begun to explore ways in which men can challenge norms and expectations of masculinity. As these discursive studies have been able to critique some of the social norms regarding men and health behaviours, they have highlighted the contribution potential of further discursive work into the field. These studies demonstrate that discursive work may help to further critique, understand, and explore the interface between masculinity and mental health.

2.3.3 Thematic analysis of interview data

Having explored both published research and news media portrayals of men with depression, I turned my attention to investigating how men made sense of their own experiences of depression. I questioned how men's subjectivities of depression would relate to stressors and vulnerabilities to depression that I identified in the systematic review (Chapter 3), and how men were able to communicate about and seek help for depression in the face of stigma that I had explored in the media analysis (Chapter 4).

The data for the study presented within Chapter 5 were interviews with participants of the Florey Adelaide Male Ageing Study (FAMAS) (Martin, Haren, Middleton, & Wittert, 2007). The FAMAS is a longitudinal cohort study of almost 1200 men selected randomly from the north-west regions of Adelaide, Australia. At the time they were recruited, all participants were between the ages of 35 and 80. The study has now been running for over 10 years, and has generated a large corpus of health-related data about the participants, including measures of bone density, whole body and regional body fat, uroflowometry, androgens, lipids, glucose, prostate specific antigen, and reproductive hormones. Participants' depressive symptoms have also been assessed using the Beck Depression Inventory (BDI) (Beck et al., 1988). Psychosocial measures of participants have also been assessed including mental health questionnaires, items of social functioning, and quality-of-life-related items (Martin, Haren, Taylor, Middleton, & Wittert, 2007).

The aim of my particular study was to explore men's experiences of depression. To collect data relevant to this research question, I conducted interviews with FAMAS participants with high depressive symptoms as identified by their scores on the BDI. As noted in Chapter 1, there is a large body of research that has looked at women's experiences of depression, with a relatively small amount of research exploring that of

men. Therefore, more knowledge about men's experiences and understandings of depression might help to inform policy and practice specifically for men. Ridge, Emslie, and White (2011) have called for research to focus on exploring men's subjectivities of distress, and this interview study begins to explore this issue.

An interview approach was chosen because interviews would allow me to consider men's own discourses of depression. Interviews were thought to be preferable over: a) a focus group approach which may have made men feel uneasy about talking about such a sensitive topic with others present, or b) a written survey questionnaire which may not have yielded useful in-depth data. A benefit of conducting interviews, however, was that they would allow me to obtain detailed responses to questions, and would provide me with an opportunity to thoroughly question and explore men's subjectivities of distress and depression.

After obtaining approval from the Royal Adelaide Hospital Research Ethics Committee (Appendix A), I contacted FAMAS participants with high depressive symptoms at random to schedule individual interviews. Interviews were open-ended and held at participants' homes (with the exception of an interview with one participant who preferred to hold the interview in his workplace) with an emphasis on building rapport and allowing men to narrate their own experiences. The interview questions explored participants' understandings of their health, stress and coping. Participants were not informed that I was primarily interested in the ways in which they would speak about depression. Rather, in asking them questions about health, stress, and coping, participants were able to orient to their experiences of depression in ways that were personally relevant. This was in an attempt to reduce my preconceived expectations about their depression narratives. All participants discussed their experiences of depression through the course of their interviews. Appendix B provides an overview of the topics for discussion during the interviews.

Each interview was transcribed and I used a thematic analytic approach to analyse the data (Braun & Clarke, 2006). For the news media study presented in Chapter 4, I used a thematic approach to identify my theme of interest (men's communication about their depression), which I then explored in depth with a discursive psychological approach. For the interview study presented in Chapter 5, however, I provide a much broader overview of the range of themes present in the interview data set. I followed Braun and Clarke's (2006) approach to analysing the whole data set.

This thematic analytic approach involves a number of decisions about how the analysis will take place (see Braun & Clarke, 2006, for a detailed outline of these decisions). The first decision I had to make was whether or not the thematic analysis would provide a rich description of the data set, or a detailed account of one particular aspect of the data set. Given that there is little research exploring men's subjectivities of their distress (Ridge et al., 2011), I felt it was more important in this study to report the wide range of themes across the data set, rather than focus on one aspect (as was the approach with the news media data). A focus on the breadth of the data provided an opportunity to explore the wide range of patterns in the ways men spoke to me about their experiences with depression.

In conducting thematic analysis, the second decision to make is that of the 'size' of a theme. This refers to how the researcher decides what constitutes a theme. An aspect of the data may constitute a theme if it is important or prevalent within the overall data set, or it may constitute a theme if it is important or prevalent within an individual datum (a single interview as opposed to the entire set of interviews, for example) (Braun & Clarke, 2006).

The third decision when undertaking a thematic analysis is whether analysis will be inductive or theoretical (Braun & Clarke, 2006). An inductive (data-driven) thematic

analysis is driven by the themes the researcher identifies in the data, and does not necessarily attempt to force the data to map on to a particular theoretical background. In a theoretical thematic analysis, the analytic approach is theory-driven. In such an analysis, the researcher would code the data according to the theoretical approach identified before analysis. I decided to use a synthetic approach to thematic analysis. Fereday and Muir-Cochrane (2006) have written about the strengths of such approaches to thematic analysis. Specifically, they emphasise that a combination of data-driven and theory-driven coding allows researchers to have their theoretical underpinnings remain integral to analysis, while still retaining flexibility for new information to be explored directly from the data. My analysis was informed strongly by theories and findings from the previous studies in my dissertation, including: theories of masculinity and depression elaborated on in my media analytic study, as well as by the factors associated with depression identified in my systematic review. However, throughout the coding process, I aimed to remain open to new codes that may not necessarily fit such theories, but that may have been prevalent in the interview data.

The fourth decision of a thematic analysis is whether the themes are identified at the semantic or the latent level (Braun & Clarke, 2006). In a semantic approach, themes are analysed within the surface meanings of the data and not at a level beyond what the text or talk says. In a latent approach, themes are analysed at a deeper level in order to explore concepts underlying the data. Given that my overall research project was driven by a poststructuralist perspective, I chose a latent approach to thematic analysis, with particular attention to how gendered and medicalised language and communication shaped the themes within my data.

The thematic approach to this analysis was chosen for a number of benefits as outlined by Braun and Clarke (2006). First, the approach allowed for both data-driven and theory-driven analysis. Second, it was appropriate for the large data set anticipated

for an interview study. Some of the interviews that I conducted for the study were longer than an hour in duration. A large data set was produced by these interviews, and a thematic analytic approach enabled me to manage data of this magnitude. Third, it allowed me to provide an overview of the entire data set. This was important because there is not a lot of academic literature published about men and their subjectivities of depression. A thematic analytic approach – with the ability to report on and analyse the breadth of a data set – was particularly suited to a developing research area such as men’s subjectivities of depression.

In coming to this research project on men’s experiences with depression, I had never experienced depression first hand. Although members of my family and friends had experienced mental health concerns, I had never had any first-hand experience. Many of the participants in the third study in this dissertation (Chapter 5) were at least twice my age and all had experienced very high levels of depressive symptoms. One concern about the interview process would be that participants would perceive me to be too young, or too inexperienced in mental health issues to understand their concerns. I was also concerned about whether not having had depression would influence my perceptions of depression as constructed through a) scientific literature as in Chapter 3, b) news media portrayals as in Chapter 4, and c) interviews with men with high depressive symptoms as in Chapter 5. However, although I have never personally experienced depression, I do live within the sociocultural and historical context relevant to current conceptions of masculinity and depression. For example, in terms of masculinity, I have often heard people say that men will not talk about their problems, and have personally drawn on that discourse of masculinity as autonomous, independent, and stoic. Indeed, in a Western context, men are portrayed as being uncommunicative about issues and as out of touch with their emotions. Specifically within an Australian context, the types of masculinity that have come to be celebrated

typically ridicule emasculation, and are stoic and independent (Murrie, 1998).

Therefore, in approaching my research, I had assumed that it would be difficult to collect interview data from men about their experiences with depression because of my subjectivities of masculinity. In terms of depression, most of the images of depression culturally available to me were of women, and were of pain and suffering. In trying to maintain a poststructuralist view throughout my research, I had to question these assumptions – that men would not talk about problems, that depression was a ‘women’s disease’, or that depression was painful and that people with depression were sufferers.

Before conducting the research interviews with men who were all aged over 45, as mentioned, I was concerned that my younger age would be another barrier to the data collection process. Not only had I never experienced depression before, but also being in my late-20s, I had less life experience in general than my participants. In order to mitigate any communication difficulties throughout the interview because of this difference in age, I established an interview schedule (Appendix B) which involved a lot of rapport building. In the course of conducting the interviews, I allowed men to dictate the extent to which rapport was built. For some participants, it became apparent that the interview process was merely an information-sharing session, and they did not appear to want to engage in rapport-building. In other interviews, I found that participants preferred having a friendly chat before moving on to the interview schedule. I followed the participants’ lead as much as possible. Furthermore, in inviting men to participate in the study, I did not describe it as focussing specifically on depression; rather, the study was described as being concerned with the participants’ experiences of health, stress and coping. This framing of the study meant that participants were able to introduce and talk about their experiences of depression in their own words – and, furthermore, this approach allowed me to hear about these

experiences, without asking directly, which may have been difficult if participants were concerned about my status as a younger, less experienced individual.

In terms of the participants themselves, I did give much consideration to whether it would be best to include only men who had experienced high levels of depressive symptoms (as I eventually decided) or whether all men would be able to discuss issues around subjectivities of depression. Although all men would be able to talk about subjectivities of depression, I had identified the research gap in terms of depressed men's subjectivities of depression, so that is what I pursued in the current research.

In the following three chapters I present each of the three study manuscripts that form this dissertation. These three chapters are followed by a discussion chapter that elaborates on the overall findings, implications, and limitations.

Chapter 3

Development of Men's Depressive Symptoms: A Systematic Review of Prospective Cohort Studies

Statement of Authorship

Title of Paper	Development of Men's Depressive Symptoms: A Systematic Review of Prospective Cohort Studies
Publication Status	<input checked="" type="radio"/> Published, <input type="radio"/> Accepted for Publication, <input type="radio"/> Submitted for Publication, <input type="radio"/> Publication style
Publication Details	Scholz, B., Crabb, S., & Wittert, G. (2013). Development of men's depressive symptoms: A systematic review of prospective cohort studies. <i>Journal of Men's Health</i> , 10(3), 91-103.

Author Contributions

By signing the Statement of Authorship, each author certifies that their stated contribution to the publication is accurate and that permission is granted for the publication to be included in the candidate's thesis.

Name of Principal Author (Candidate)	Brett Scholz		
Contribution to the Paper	Sourced publications for inclusion to review, performed review, wrote manuscript, and acted as corresponding author		
Signature		Date	

Name of Co-Author	Shona Crabb		
Contribution to the Paper	Supervised development and conduct of work, and evaluated manuscript		
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Contribution to the Paper	Supervised development and conduct of work, and evaluated manuscript		
Signature		Date	

3.1 Abstract

Background: Depression is common in men but research on the topic remains limited. This article aims to synthesize and assess published evidence about the development of depressive symptoms in men and provide an account of current findings.

Methods: Medline, the Cochrane Library, PsycINFO and Scopus were searched for prospective, observational cohort studies containing a measure of depression as an outcome variable. Studies included were those with a focus on incident depression or change in depressive symptoms. Each article was critically appraised for methodological quality. Seventy-three articles were included in the final review.

Results: Factors consistently associated with increased depressive symptoms across studies were low marital satisfaction, poor overall health, being HIV-positive, clinically-defined insomnia, stressful occupational events, and history of panic attacks.

Conclusions: There are a number of complex factors that influence the development of depression in men. Taken together, these data support the interaction of multiple stressors and an underlying vulnerability in the development of depression. The variability among the included studies, especially in regards to period of follow-up and assessment of depressive symptoms highlights the necessity for further longitudinal cohort studies examining depression in men.

3.2 Introduction

It has been predicted that the global burden of depression will be second only to HIV/AIDS by 2030, and the leading cause of disease burden in high-income countries (Mathers & Loncar, 2006). Depression may amplify the risk of mortality from co-morbid disease (Kellerman, Christensen, Baldwin, & Lawton, 2010). Depression may also increase disease risk by interfering with social judgements, such as condom use (Safren et al., 2010).

Reports of prevalence rates of depression in men as compared to women vary, although it seems that the lifetime prevalence of depression in women is close to 21% and that of men is close to 13% (Department of Mental Health and Substance Dependence, 2011). Up until 2007, studies focusing on women and depression outnumbered those on men and depression by a ratio of over three to one (Addis, 2008). This difference has been attributed, firstly, to gender-related research being more typically focused on women and, secondly, to men potentially ‘masking’ their depression and, therefore, making research difficult. In August of 2010, the authors found 1760 articles dealing specifically with depression in women, but just 479 dealing with depression in men – a ratio of almost four to one. Emerging research is increasingly considering new contexts in which men experience depression – for instance, antenatal depression in fathers (Fisher, Kopelmann, & O’Hara, 2012). The promotion and usage of community-based support networks for men with depression is also growing – see “Programs for Men” (beyondblue, 2010) for an example of such networks available in Australia for groups including workplaces, rural communities, and indigenous people. However, the disparity in attention given to depression in men continues. Moreover, doctors diagnose more women with depression than men, while men are more often diagnosed with alcohol or drug dependence and more often commit suicide (Cleary, 1997).

It has been hypothesized that depression in men may be hidden by externalising problems, or that gendered norms impact upon men's responses to negative affect (Addis, 2008). Thus there is a need to research differences between and within men in regards to the experience of depression. This review is concerned with outlining the predictors of depressive symptom development specifically in men in non-clinical settings.

3.3 Method

3.3.1 Inclusion criteria

Types of studies

Prospective, observational cohort studies were included in this review. Only studies published in English were considered.

Types of participants

Studies were included if participants were men aged 18 or over at the time of follow-up. Studies that included women in their population were included only where analysis was performed separately by gender.

Types of outcome

Studies were included where the results contained an outcome of a measure of depressive symptoms such as the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) or a clinical diagnosis of depression such as made by the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). Throughout the review, the terms 'higher' or 'lower' depressive

symptoms are used to refer to a higher or lower score as assessed by such scales. Scoring of depression inventories relates to (but is not always identical to) physicians' assessments of depressive symptoms and to clinical diagnosis (Corruble, Legrand, Zvenigorowski, Duret, & Guelfi, 1999; Cunningham, Wemroth, von Knorring, Berglund, & Ekselius, 2011). While there are several differences between scales, they are useful for indicating the severity of depressive symptoms and hence are appropriate for this review (Demyttenaere & de Fruyt, 2003).

3.3.2 Search strategy

The search terms used were 'depression', 'depressive', 'men', 'male', 'man', 'masc*', 'prospective', and 'longitudinal'. The electronic databases searched were MEDLINE, Cochrane Library, PsycINFO and Scopus. The final step of the search strategy was to search manually through the reference lists of identified articles for additional studies.

3.3.3 Review methods

Data collection

After searching through the aforementioned databases, 4276 references were located. Duplicate articles were removed. The titles and abstracts were appraised and a total of 703 of these references were deemed relevant for further reading. The full texts of these articles were acquired and each article was then evaluated against the inclusion criteria. The first author evaluated each article and this process was repeated by the other authors. Seventy-three studies were included in the final review. A summary of all included studies is given in Table 1.

Methodological assessment

The first author independently assessed studies identified for potential inclusion against inclusion criteria. All three authors then reviewed the assessed articles and discussed the methodological quality of each article including appropriateness of study design, blinding of assessment, sample size, follow-up duration and completeness. Any disagreements regarding specific articles were resolved through discussion.

Data extraction

Multivariate analyses where prospective depressive symptoms in men were the outcome were extracted from each study along with details about each study population and study methods used.

Data synthesis

Verbeek, Ruotsalainen, and Hoving (2012) discuss how best to synthesize results for systematic review. A narrative synthesis was performed for this review due to significant heterogeneity in the identified studies. In this approach, results are not statistically combined, but are described as well as possible (Verbeek et al., 2012). Results are grouped by risk factor category.

Table 1

Summary of Included Articles

First author, year	Age at baseline	Country	Follow-up	Measure of Depression
Ahern, 2008	17-18	USA	48 years	CES-D
Alford, 1995	18	USA	4 weeks	BDI
Ancelin, 2010	65+	France	7 years	MINI and CES-D
Arola, 2010	50+	UK	3 years	HADS-D
Aseltine, 1993	18-65	USA	3 years	HSC
Augestad, 2008	21-40	Norway	13 years	HADS-D
Barroso, 2002	18-51	USA	7.5 years	POMS
Bjerkeset, 2005	21-40	Norway	13 years	HADS-D
Bjerkeset, 2008	21-40	Norway	13 years	HADS-D
Bruce, 1992	18-60	USA	1 year	DIS
Canals, 2002	11-12	Spain	7 years	BDI
Chang, 1997	M=26	USA	45 years	Clinical diagnosis
Choi, 1997	12-18	USA	4 years	6-item scale
Clays, 2007	39-59	Belgium	8 years	CES-D
Coventry, 2009	18-95	Australia	12 years	DSM or SCD
Dew, 1997	18+	USA	1 year	DSM
Dryman, 1991	18+	USA	1 year	DIS
Duncan, 2005	11-21	USA	1 year	CES-D
First author, year	Age at baseline	Country	Follow-up	Measure of Depression

	baseline			Depression
Dussault, 2011	6	Canada	17 years	DIS
Ernst, 1991	20-21	Switzerland	9 years	DSM
Fergusson, 2002	Birth	New Zealand	21 years	CIDI
Fernandez, 1998	58-64	USA	2 years	CES-D
Flensburg- Madsen, 2011	20+	Denmark	26 years	ICD
Fletcher, 2009	15-20	USA	6 years	CES-D
Forman- Hoffman, 2007	53-63	USA	2 years	CES-D
Forman- Hoffman, 2008	53-63	USA	2 years	CES-D
Frisco, 2010	15-20	USA	1 year	CES-D
Frost, 1999	5	USA	13 years	CDI
Fujiwara, 2008	25-74	USA	3 years	CIDI
Galaif, 2003	14-19	USA	1 year	CES-D
Gallo, 1993	40+	USA	1 year	DIS
Gariepy, 2009	18-80	Canada	12 years	CIDI short form
Geerlings, 2002	55-85	Netherlands	3 years	CES-D
Giltay, 2009	65-84	Finland, Italy and the Netherlands	15 years	Zung SDS
Giltay, 2010	50-69	Finland and Italy	3 years	Zung SDS
Goodwin, 2004	15-21	New Zealand	3 years	CIDI
Griffin, 2002	35-55	UK	14 years	GHQ-D

First author, year	Age at baseline	Country	Follow-up	Measure of Depression
Gutman, 2004	11-15	USA	8 years	9-item scale
Hallfors, 2005	11-21	USA	1 year	CES-D
Horwitz, 1991	21	USA	3 years	SCL-90-R
Hurre, 2007	16	Finland	16 years	BDI
Idler, 1992	65+	USA	7 years	CES-D
Kendler, 2006	Adult, not specified	USA	4 years	DSM
Kim, 2003	M=10	USA	14 years	CES-D
Kivelä, 1996	61+	Finland	5 years	DSM
Koizumi, 2005	70+	Japan	1 year	GDS
Korhonen, 2007	17+	Finland	15 years	BDI
Kouros, 2008	M=40	USA		CES-D
LaPierre, 2009	19+	USA	7 years	CES-D
Marmot, 2001	35-55	UK	5 years	GHQ-D
Meadows, 2006	15-20	USA	8 years	CES-D
Melchior, 2010	40-50	France	5 years	DSM
Mikkelsen, 2010	20-93	Denmark	18 years	ICD
Niedhammer, 1998	46-56	France	1 year	CES-D
Paterniti, 2002	40-50	France	3 years	CES-D
Pelkonen, 2003	16	Finland	6 years	BDI
Petts, 2008	15-20	USA	1 year	CES-D
Rotermann, 2007	20-64	Canada	10 years	CIDI

First author, year	Age at baseline	Country	Follow-up	Measure of Depression
Sadowski, 1999	5	UK	28 years	DSM
Schulz, 2009	65+	USA	5 years	CES-D
Shores, 2005	50+	USA	4 years	ICD
Smith, 2010	71-93	USA	8 years	CES-D
Stoetzer, 2009	20-64	Sweden	3 years	MDI
Stoolmiller, 2005	15-24	USA	17 years	CES-D
Sui, 2009	35-55	USA	12 years	CES-D
Tanaka, 2011	40-69	Japan	7 years	DSM
Terre, 2003	20-77	USA	5 years	CES-D
Uddin, 2010	15-20	USA	1 year	CES-D
Virtanen, 2011	44-66	UK	7 years	GHQ-D
Vogelzangs, 2010	70-79	Netherlands	5 years	CES-D
Wells, 2010	20+	USA	6 years	PHQ
Williams, 2009	45-59	UK	18 years	GHQ-D
Zammit, 2004	18-20	Sweden	27 years	ICD

CES-D: Center for Epidemiologic Studies Depression Scale. BDI: Beck Depression Inventory. MINI: Mini International Neuropsychiatric Interview. HADS-D: Hospital Anxiety and Depression Scale. HSC: Hopkins Symptom Checklist. POMS: Profile of Mood States. DIS: Diagnostic Interview Schedule. DSM: Diagnostic and Statistical Manual of Mental Disorders Criteria. SCD: Sub-clinical depression. CIDI: Composite International Diagnostic Interview. ICD: International Statistical Classification of Diseases and Related Health Problems Criteria. Zung SDS: Zung Self-rating Depression Scale. GHQ-D: General Health Questionnaire Depression Scale. SCL-90-R: Symptom Checklist 90 Revised.

3.4 Results

3.4.1 Social and demographic factors

Table 2 provides an outline of social and demographic factors that were examined in included studies and indicates whether factors were associated with an increase, decrease or no change in depressive symptoms. Factors with disparate results across or within studies are discussed in further detail below. Factors that were not found to be associated with depressive symptoms across all relevant studies were being a parent, household size, and living in an urban area. Marital satisfaction was associated with fewer depressive symptoms across all relevant studies.

Age

The majority of these studies found no relationship between age and men's incident depressive symptoms over time. Those that did find a relationship involved populations with a small age range (Duncan & Rees, 2005; Griffin, Fuhrer, Stansfeld, & Marmot, 2002; LaPierre, 2009; Marmot, Shipley, Brunner, & Hemingway, 2001; Schulz et al., 2009; Shores, Moceris, Sloan, Matsumoto, & Kivlahan, 2005) or specific populations such as a US military cohort (Wells et al., 2010) or HIV-positive men (Dew et al., 1997).

Marital status

Findings indicated a lower incidence of depressive symptoms in married men than men of any other relationship status. One study suggested that this association is significant only in men in the age group of 19-39, and that a first marriage is associated with fewer depressive symptoms than any subsequent marriage (LaPierre, 2009).

Table 2

Social and Demographic Factors and Depressive Symptoms

A plus sign indicates an increase in depressive symptoms, a minus sign indicates a decrease in depressive symptoms, and a zero indicates no effect of either type.

Combinations of these indicate mixed findings within the study, and this is discussed further within the results.

Study	Age	Married	Marital Satisfaction	Same-sex attraction	Education	Children	Household size	Education in Immediate	Parents' marital disruption	Raised in non-nuclear	Depression in close	Providing care for family	Parent-youth relationship	Urban	Retired	High job demands	High decision latitude	Low employment grade	Income	Non-white	
Ahern, 2008		0			0		0								0						
Aseltine, 1993		-																			
Augestad, 2008	+				-	0	0														
Bjerkeset, 2005	0	-			-																
Bruce, 1992		-	-																		
Choi, 1997																					-
Clays, 2007																0	0				
Coventry, 2009	+																				
Dew, 1997	-				0																
Dryman, 1991	0																				
Duncan, 2005	+			+				-		+				0							+/-
Fernandez, 1998					0										-/+						-
Fletcher, 2009								-	0					0						0	0
Frost, 1999									0												
Fujiwara, 2008																					-0/+
Gallo, 1993				0	0																

Study	Age	Married	Marital Satisfaction	Same-sex attraction	Education	Children	Household size	Education in Immediate	Parents' marital disruption	Raised in non-nuclear	Depression in close	Providing care for family	Parent-youth relationship	Urban	Retired	High job demands	High decision latitude	Low employment grade	Income	Non-white
Griffin, 2002	-	0				0						+					0	0		
Gutman, 2004													0							
Hallfors, 2005				+																
Horwitz, 1991		0			0	0														
Huurre, 2007		-			0								+/0					+		
Idler, 1992	0																			
Kim, 2003		-									+/0								0	
Kivelä, 1996											0									
LaPierre, 2009	-/0	-/0			-/0															+/0
Marmot, 2001	-/0																	+/0		
Melchior, 2010	-	-																	0	
Niedhammer, 1998	0	-			0												-	+		
Paterniti, 2002																+	-	+/0		
Petts, 2008					0		0	0												
Rotermann, 2007	0	-			-/0	0														
Sadowski, 1999									+											
Schulz, 2009	+				0													0		0
Shores, 2005	+/0																			
Stoolmiller, 2005											+									
Terre, 2003	0																		0	
Uddin, 2010	0									0										+
Wells, 2010	+	0			0													+		0
Williams, 2009	0																	+		

Same-sex attraction

Being attracted to other men was not associated with a change in depressive symptoms in young men (Petts & Jolliff, 2007), while having had sex with other men during adolescence was associated with higher depressive symptoms in early adulthood (Hallfors, Waller, Bauer, Ford, & Halpern, 2005).

Education

The majority of studies found no relationship between level of education and longitudinal depressive symptoms. One study suggested that higher education was associated with fewer depressive symptoms only in men younger than 40 years of age (LaPierre, 2009). The education level of one's partner did not have an impact upon incident depressive symptoms (Schulz et al., 2009)

Occupational/Employment factors

There was not enough evidence to draw significant conclusions about a relationship between being retired and change in depressive symptoms. Of the two studies that assessed this relationship, one found that retirement was associated with lower depressive symptoms for white participants (Ahern & Hendryx, 2008), and higher depressive symptoms for those who identified as African American (Fernandez, Mutran, Reitzes, & Sudha, 1998).

Two studies assessed job demands. One, based on a three-year study of men from one company found increased depressive symptoms in men with high job demands (Paterniti, Niedhammer, Lang, & Consoli, 2002). The other, from across nine companies over eight years, found no association (Clays et al., 2007) suggesting that job demands alone are not associated with change in depressive symptoms. This study had

tested the demands-control-support model (Karasek, 1979) which posits that high job demands alongside low decision latitude and low workplace social support will lead to adverse health effects. There are few longitudinal studies testing this model and they provide less support for the model than the cross-sectional studies available. While the study by Clays et al. (2007) found there was no interaction effect between job demands and decision latitude, the interaction between high job demands and low workplace social support was significantly associated with higher depressive symptomatology in men, providing support for the demand-support hypothesis. Further research is needed to assess the control aspects of this model.

Of the four studies that analysed the association between occupational decision latitude and depressive symptom change, the two that found an association were reporting on data from the same population (Niedhammer, Goldberg, Leclerc, Bugel, & Davis, 1997; Paterniti, Niedhammer, Lang, & Consoli, 2002). The other two studies were of broader populations and longer periods of follow-up (Clays et al., 2007; Griffin, Fuhrer, Stansfeld, & Marmot, 202). This suggests that decision latitude alone may not be associated with change in depressive symptoms over time.

Results indicated that what might be considered a lower employment grade was associated with an increase in depressive symptoms. One study which found no relationship between employment level and depression involved a population comprised only of British civil servants (Griffin et al., 2002), while the remaining studies observed a broader range of occupations in both corporate (Niedhammer et al., 1998) and military contexts (Wells et al., 2010). Men belonging to a manual working class had higher depressive symptoms at follow-up than men in non-manual classes (Huurre, Eerola, Rahkonen, & Aro, 2007; Williams et al., 2009).

Income

Findings regarding the impact of income on depressive symptoms were inconclusive regardless of whether studies examined household income (Ahern & Hendryx, 2008; Terre, Poston, Foreyt, & St. Jeor, 2003), personal income (Fernandez, Mutran, Reitzes, & Sudha, 1998; Melchior, Chastang, Leclerc, Ribet, & Rouillon, 2010), or parental income (Choi, Patten, Gillin, Kaplan, & Pierce, 1997; Duncan & Rees, 2005; Fletcher, 2009; Kim, Capaldi, & Stoolmiller, 2003; Uddin et al., 2010). These findings suggest that income is a poor predictor of depressive symptom change in men.

Family environment

Two studies found higher longitudinal depressive symptoms in men whose family members had lower levels of education. One study, which was from a sample of Latino adolescents from the USA, reported no relationship (Petts & Jolliff, 2007).

There were no definitive results regarding incident depressive symptoms in men whose parents had experienced marital instability, but data suggest that age at the time of parents' marital disruption may play a role in such an association. Men who were aged five or younger when their parents experienced marital instability were more likely to have higher depressive symptoms in adulthood (Sadowski, Ugarte, Kolvin, Kaplan, & Barnes, 1999). Measured at age eight or older, there was no significant association between parental marital instability and adulthood depressive symptoms (Fletcher, 2009; Frisco, Houle, & Martin, 2010).

Findings were inconclusive as to whether being raised in a nuclear family was associated with change in adulthood depressive symptoms. One study found that being raised in any circumstances other than a two-parent home was associated with higher

depressive symptoms (Duncan & Rees, 2005), and another (from a Latino sample of participants) suggested that there was no difference in depressive symptoms in respect to the family structure in which men were raised (Petts & Jolliff, 2008).

Men whose parents had experienced depression were more likely to have higher adulthood depressive symptoms. One study found that this was only the case for men whose parents both had depression (Kim, Capaldi, & Stoolmiller, 2003). There was no association for depression in other close relatives (Kivelä, Kongäs-Saviaro, Kimmo, Kesti, & Laippala, 1996).

Providing care for family members was associated with change in depressive symptoms at follow-up. Specifically, providing moderate financial or informal support was associated with fewer depressive symptoms than providing no support or high levels of support (Fujiwara & Lee, 2008). Providing emotional support (Fujiwara & Lee, 2008) or taking on a caregiving role for a family member (Griffin et al., 2002) was associated with increased depressive symptoms.

The quality of an individual's relationship with their parents did not seem to be associated with incident depressive symptoms. One study found that it was only in men of lower socioeconomic backgrounds that a poor relationship with their father was associated with depressive symptoms (Huurre et al., 2007)

Race/ethnicity

All six studies that analysed the relationship between race/ethnicity and depressive symptoms were carried out in the USA (Duncan & Rees, 2005; Fletcher, 2009; LaPierre, 2009; Shores, Mocerri, Sloan, Matsumoto, & Kivlahan, 2005; Uddin et al., 2010; Wells et al., 2010). In this context, findings revealed a complex relationship between race and depressive symptoms. While the majority of studies found no

significant association between race and depressive symptoms, both work stress and retirement were associated with higher depressive outcomes in African American men than in other men (Fernandez et al., 1998).

Social connectedness

The mixed findings for social connectedness may be attributable to the heterogeneity of measures of social contacts and social supports. Findings suggest that a greater number of social contacts in adulthood (but not in adolescence [Frost, Reinherz, Pakiz-Camras, Giaconia, & Lefkowitz, 1999] or early adulthood [Huurre et al., 2007]) is associated with fewer depressive symptoms (Huurre et al., 2007). Articles that discussed the relationship between social support and depressive symptom change suggest that greater social support is associated with fewer depressive symptoms. However, there was no relationship between social support and depressive symptom change in men experiencing high levels of stress (Coventry et al., 2009) or men whose social support was measured in terms of the number of recent visits they had received from family or friends (Ahern & Hendryx, 2008). Further, social support from a household member – but not from friends or a partner – was associated with fewer depressive symptoms in a cohort of HIV-positive men (Dew et al., 1997).

3.4.2 Health Behavior Factors

A summary of the findings of the relationship between health behaviors and incident depressive symptoms is provided in Table 3. Across studies, sexual experimentation was not associated with depressive symptoms. Factors with more disparate findings are described below.

Alcohol

Most findings indicated that regular moderate alcohol consumption was not associated with incident depressive symptoms. However, depressive symptoms were elevated in young men who experimented with both alcohol and sex (Hallfors, Waller, Bauer, Ford, & Halpern, 2005)⁵² men who drank excessive alcohol (Bjerkeset, Nardahl, Mykletun, Holmen, & Dahl, 2005; Sui et al., 2009; Williams et al., 2009), and men who had become dependent on alcohol (Wells et al., 2010).

Illicit drug use

The findings for the impact of illicit drug use on depressive symptoms were too heterogeneous to draw definitive conclusions. One study found a relationship between marijuana use during adolescence and increased depressive symptoms in adulthood (Hallfors et al., 2005), while another study with a much longer period of follow-up found no relationship (Frost et al., 1999). This could suggest that results indicating a positive relationship between marijuana use and depressive symptom increase may not be generalizable. Findings indicated that drug misuse is associated with high depressive symptoms (Kendler, Gardner, & Prescott, 2006). The one study that found otherwise was of a cohort of HIV-positive men and thus may not be generalizable to broader contexts (Dew et al., 1997).

Table 3

Health Behavior Factors and Depressive Symptoms

Study	Sex experimentation	Alcohol	Illicit drug use	Smoking	Regular physical activity
Augestad, 2008		0		0	0/-
Bjerkeset, 2005		+		+	-
Choi, 1997				+/0	
Dew, 1997			0		
Duncan, 2005				+	
Flensburg-Madsen, 2011				+/0	
Frost, 1999			0		
Hallfors, 2005	0	+/0	+/0		
Kendler, 2006			+		
Korhonen, 2007				+/0	
Mikkelsen, 2010					0
Petts, 2008	0				
Smith, 2010					-/0
Sui, 2009		0		+	
Tanaka, 2011		0		0	-
Wells, 2010		+		+	
Williams, 2009		+/0		0	

Smoking

Regular smoking was associated with heightened depressive symptoms at follow-up in the majority of relevant studies. Smoking occasionally (Korhonen et al., 2007) or experimentally (Choi et al., 1997) was not associated with depressive symptom change. Attitudes towards smoking are likely to be different across cultures and age groups, and this may moderate any relationship with depressive symptoms.

Physical activity

Depressive symptoms were found by the majority of these studies to be higher at follow-up in men who engaged in no physical activity. One study suggested that men who had poor overall health did not differ in depressive symptoms whether or not they participated in physical activity (Smith et al., 2010).

3.4.3 Disease Status and Risk Factors

Table 4 provides a summary of the results of studies that looked at the associations between depressive symptoms and factors related to disease. Poor overall health, having HIV, and clinically-defined insomnia were all related to incident high depressive symptoms across studies. Self-rated amount of sleep and sleep quality, diabetes and cancer were not associated with depressive symptom change across studies. Factors with mixed findings are reviewed below.

Table 4

Disease Status and Risk Factors and Depressive Symptoms

Study	Poor overall health	HIV+	Sleep Problems	Fatigue	Diabetes	Cancer	Lung impairment	Heart conditions	Presence of chronic disease	Cholesterol	Loss of sexual desire	BMI	Pain	Lowered physical ability	Prior depression	Anxiety
Ahern, 2008	+												+		+	
Alford, 1995															+	+
Ancelin, 2010										+						
Arola, 2010													+			
Augestad, 2008												+/0				
Barroso, 2002		+		0											+	+
Bjerkeset, 2005								+/0				+			+	
Bjerkeset, 2008												+/0				

Study	Poor overall health	HIV+	Sleep Problems	Fatigue	Diabetes	Cancer	Lung impairment	Heart conditions	Presence of chronic disease	Cholesterol	Loss of sexual desire	BMI	Pain	Lowered physical ability	Prior depression	Anxiety
Canals, 2002															+/0	-/0
Chang, 1997			+/0													
Dew, 1997		+													+	0
Dryman, 1991			0	+							+					
Dussault, 2011															0	
Ernst, 1991			+													
Fergusson, 2002															+	
Fernandez, 1998	+														+	
Forman-Hoffman, 2007									0						+	

Study	Poor overall health	HIV+	Sleep Problems	Fatigue	Diabetes	Cancer	Lung impairment	Heart conditions	Presence of chronic disease	Cholesterol	Loss of sexual desire	BMI	Pain	Lowered physical ability	Prior depression	Anxiety
Forman-Hoffman, 2008					0	0	0	0	0					0		
Frost, 1999															+	
Frisco, 2010												+/0				
Gariepy, 2010												-				
Geerlings, 2002													+			
Giltay, 2009										-/0						
Giltay, 2010							+									
Gutman, 2004															+	
Idler, 1992									0				0	+/0	+	

Study	Poor overall health	HIV+	Sleep Problems	Fatigue	Diabetes	Cancer	Lung impairment	Heart conditions	Presence of chronic disease	Cholesterol	Loss of sexual desire	BMI	Pain	Lowered physical ability	Prior depression	Anxiety
Kendler, 2006															+	
Kivelä, 1996	+			0	0	0	0	0	0		0		0		+/0	
LaPierre, 2009															+	
Pelkonen, 2003															+	
Petts, 2008															+	
Schulz, 2009								0								
Shores, 2005									+/0							
Stoolmill er, 2005															+	
Sui, 2009					0			0				+/0				
Tanaka, 2011			0						+			0				

Study	Poor overall health	HIV+	Sleep Problems	Fatigue	Diabetes	Cancer	Lung impairment	Heart conditions	Presence of chronic disease	Cholesterol	Loss of sexual desire	BMI	Pain	Lowered physical ability	Prior depression	Anxiety
Terre, 2003														○	+	
Vogelzangs 2010											0					

Medical conditions

The onset of lung disease (Giltay et al., 2010) and the onset of pulmonary disease (Kivelä et al., 1996) were not associated with change in depressive symptoms over time. However, a further study suggested that men with lower forced vital capacity had higher depressive symptoms independent of the presence of chronic disease (Giltay et al., 2010)

Of the five studies that investigated heart conditions and depressive symptoms, only one found that myocardial infarction was associated with heightened longitudinal depressive symptoms (Bjerkeset, Nordahl, Mykletun, Holmen, & Dahl, 2005). Studies that found no association between heart conditions and depressive symptoms had a markedly small proportion of men with depressive symptoms (Kivelä et al., 1996), were based on self-report measures of illness from ageing populations (Forman-Hoffman et al., 2008), potentially influencing the results.

No definitive conclusions could be drawn about the association between the presence of any (non-specific) chronic disease and depressive symptoms. Such a finding may not be unexpected as chronic diseases is a heterogeneous predictor.

Cholesterol

Findings suggest that some forms of cholesterol may be related to change in depressive symptoms with time. Low total serum cholesterol was associated with an increase in depressive symptoms (Ancelin et al., 2010). Lower levels of low-density lipoprotein cholesterol were associated with an increase in depressive symptoms in one study (Ancelin et al., 2010) but not in another (Giltay et al., 2010).

Obesity

Findings regarding body mass index and incident depressive symptoms differed considerably between studies, and no definitive conclusion could be drawn. One study suggested that the men who perceive themselves to be either overweight or underweight have higher depressive symptoms than other men (Frisco et al., 2010).

Pain

Men with many pain symptoms or men whose pain interfered with daily activities had higher longitudinal depressive symptoms than men with no pain. The two studies that did not find an association between pain and depressive symptoms looked only at a small number of types of pain, which may have failed to capture all experiences of pain (Idler & Kasl, 1992; Kivelä et al., 1996).

Lowered physical ability

Lowered physical ability was associated with an increase in men's depressive symptoms at follow-up. The study that found no such relationship examined only specific functional limitations, rather than all aspects of physical ability (Forman-Hoffman et al., 2008). One study did find that men who practised religion privately were protected from the association between functional disability and depressive symptoms (Idler & Kasl, 1992). No relationship was found between "distress arising from perceptions of bodily dysfunction" and depressive symptoms (Terre et al., 2003, p.263).

Prior depression and depressive symptoms

Having had depression previously was associated with increased depressive symptoms at follow-up. The studies that reported findings to the contrary indicated no elevated depressive symptoms in men who had received treatment for their previous depression (Kivelä et al., 1996), and that depressive symptoms during adolescence were not associated with increased depressive symptoms in adulthood (Canals, Domènech-Llaberia, Fernández-Ballart, & Martí-Henneberg, 2002; Dussault, Brendgen, Vitaro, Wanner, & Tremblay, 2011).

Anxiety

Anxiety was associated with incident depressive symptoms in most relevant studies. It was reported, however, that HIV-positive men with a self-reported history of generalized anxiety (prior to baseline) were no more likely to have high depressive symptoms than were HIV-positive men without such a history (Dew et al., 1997). Another study found that anxiety at ages 12 and 18 was associated with higher

adulthood depressive symptoms, but that there was no relationship for anxiety at ages 13, 14 or 15 (Canals et al., 2002).

Sexual desire

Several depressive inventories (including the BDI [Beck et al., 1961]) include a question about loss of interest in sex (a complete loss of interest in sex would score the highest in relation to depressive symptoms). The review yielded no conclusive findings for an association between sexual desire and depressive symptoms over time. One study found no association in a cohort of ageing men (although other normative ageing processes may impact this relationship) (Kivelä et al., 1996).

Fatigue

As with sexual desire, above, fatigue appears as an item in most depressive inventories. Findings for the longitudinal relationship between fatigue and depressive symptoms were inconclusive. Although two studies found no association, one of these was of a cohort of HIV-positive men (Barroso et al., 2002), and the other was a cohort of ageing men (Kivelä et al., 1996). Thus, these findings may not generalize to the general population.

3.4.4 Psychological/Cognitive Factors

Table 5 outlines the findings for the relationships between psychological factors and depressive symptoms. Across studies, antisocial behavior was consistently not associated with incident depressive symptoms, and suicidality and a history of panic attacks were associated with an increase in depressive symptoms. Other factors are described below.

Concentration

There were insufficient data to determine whether concentration and depressive symptoms have a longitudinal association. Loss of concentration was associated with higher levels of depressive symptoms according to one study (Barroso et al., 2002), but not in an ageing cohort (Kivelä et al., 1996).

Hopelessness

Hopelessness shares construct overlap with depression. As may be expected, then, the results indicated an association between hopelessness and incident depressive symptoms. Of the three studies that looked at hopelessness, one study found no relationship between hopelessness and depressive symptoms (Kivelä et al., 1996). This study was conducted in an ageing population, which may have influenced the results.

Neuroticism

Although two of three studies did not find an association between neuroticism and depressive symptoms at follow-up (Ahern & Hendryx, 2008; Canals et al., 2002), the third provided a developmental model for depression in men in which neuroticism was associated with incident depressive symptoms (Kendler et al., 2006). It was argued that neuroticism would potentially increase sensitivity to the depressogenic effects of stressful life events.

Psychomotor change

Results indicated that some kinds of psychomotor change are associated with depressive symptom change. Specifically, it was increased psychomotor agitation (but not psychomotor retardation) which was related to increased depressive symptoms (Kivelä et al., 1996).

Table 5

Psychological/Cognitive Factors and Depressive Symptoms

Study	Concentration	Hopelessness	Neuroticism	Antisocial	Stress	Psychomotor	Panic	IQ
Ahern, 2008			0					
Alford, 1995		+						
Barroso, 2002		+						
Canals, 2002			0	0				-/0
Clays, 2007					0			
Coventry, 2009					+			
Dryman, 1991	-					0		
Ernst, 1991							+	
Fernandez, 1998					+/0			
Galaif, 2003					+			
Goodwin, 2004							+	
Kendler, 2006			+		+			
Kim, 2003				0				
Kivelä, 1996	0	0				+/0		
Meadows, 2006					+/0			
Melchior, 2010					+/0			
Niedhammer, 1998					+			
Paterniti, 2002					+			

Study	Concentration	Hopelessness	Neuroticism	Antisocial	Stress	Psychomotor	Panic	IQ
Stoolmiller, 2005					+			
Sui, 2009					+			
Terre, 2003					0			
Zammit, 2004								-/0

Stress

Greater perceived stress was associated with increased depressive symptoms at follow-up, however the measures used to assess stress across studies were highly heterogeneous. Two studies suggested that recent stress was associated with higher depressive symptoms but that former stress was not (Clays et al., 2007; Fergusson & Woodward, 2002). Of the six studies that found that increased work stress was associated with higher depressive symptoms, one found that this was significant only in African American men (Fernandez et al., 1998) and another found no relationship in men with greater cardiorespiratory fitness (Sui et al., 2009).

IQ

Some but not all aspects of IQ were found to be associated with depressive symptom change in both studies that looked at this relationship. Low reasoning aptitude at age 13 (but not at age 12 or age 14) was related to higher adulthood depressive symptoms (Canals et al., 2002), as was low mechanical ability and low overall IQ (Zammit et al., 2004). No associations were found between depressive symptoms and

general knowledge, visuospatial ability (Zammit et al., 2004), verbal aptitude (Canals et al., 2002; Zammit et al., 2004) or arithmetic aptitude (Kivelä et al., 1996).

3.5 Discussion

Several factors were found to be associated with incidence or worsening of men's depressive symptoms across studies: not being married, marital dissatisfaction, low family education, low social contact, low employment grade, parental depression, being a caregiver, excessive alcohol or alcohol dependence, smoking, no physical activity, poor health, HIV-seropositivity, clinically-defined insomnia, myocardial infarction, pain, low physical ability, prior depression, anxiety, suicidality, hopelessness, and stress. The review reveals that the following factors were not associated with change in depressive symptoms in men: being a parent, household size, whether men lived in urban or rural areas, age, education, moderate alcohol consumption, sex experimentation, self-rated amount of sleep and self-rated sleep quality (note that these were subjective measures), diabetes, cancer, and antisocial behaviour. Findings were inconclusive for many other considered factors: same-sex attraction, retirement, job demands, income, parents' marital disruption, being raised in a nuclear family, relationship with parents, race/ethnicity, social support, illicit drug use, lung impairment, having any chronic disease, levels of cholesterol, obesity, fatigue, sexual desire, concentration, neuroticism, psychomotor change, and IQ. Some findings relate to constructs that overlap with depression itself. For example, fatigue, sleep, loss of interest in sex, and hopelessness are included in several depressive inventories as items themselves. Thus it is important to not over interpret the meanings of relationships between these factors and depressive symptoms.

Several findings touch upon associations that have been previously theorized and written about more comprehensively. These include the relationships between

depression and health concerns such as cardiovascular disease, diabetes, and cancer. In interpreting the results of the review, it is important to remain mindful that in the included observational studies, the proportion of individuals in each population that, for example, had experienced cardiovascular disease, diabetes, or cancer was small. Thus there may have been insufficient statistical power for analyses involving such conditions. Clinical studies may offer further insights about potential associations between such conditions and depressive symptoms because they focus on participants with these conditions, although it is also important to note that such studies may exaggerate associations due to attention bias, expectation bias, or selection bias. The observational studies included in the review are not subject to these biases of design.

Factors associated with the development or worsening of depressive symptoms in men spanned the broad categories of social and demographic factors, psychological or cognitive factors, and factors related to disease status and risk. Many theories of depression support models suggesting that multiple stressors effect underlying vulnerabilities (Gilbert, 2006). These biological, psychological, and social factors interact as they feedback and feed-forward into one another within the individual in a complex way. For example, there were inconsistent findings between studies for the potential relationship between obesity and depressive symptoms, and there was a suggestion that men's perceptions of themselves as underweight or overweight were associated with heightened depressive symptoms. Being underweight or overweight may be associated with a vulnerability to depression, but that vulnerability may not be activated unless there are also stressors present such as the perception of oneself as being underweight or overweight.

The associations between psychological factors and depressive symptoms in this review may reflect pathoplastic relationships. Such a relationship is non-etiological and the depression both influences and is influenced by the other psychological system in

question. Men with high neuroticism, for example, respond to stress with depression; neuroticism and depression in this case are no longer distinguishable constructs (Widiger, 2011). Thus it is important not to assume causal relationships between these factors and depressive symptoms.

The literature search conducted for this study yielded a large proportion of studies that did not perform a separate analysis for men, but rather entered gender into analysis as a variable. Such an analysis creates difficulties for characterizing the predictors of change in depressive symptoms over time for each gender. It is recommended that separate analysis be included in future research as this will produce rich results about depressive symptom development in each gender.

As findings differed across studies for many risk factors, further research is needed to explain some of these discrepancies. For example, in two included studies conducted in the USA, being retired was found to have a positive relationship, a negative relationship, and no relationship with depression in different studies. It had a negative relationship with depressive symptoms for white participants, a positive relationship for African American participants (Fernandez et al., 1998), and no relationship for an ageing cohort (Ahern & Hendryx, 2008). It may be the case that where retirement is normative within one's age group, the transition is less stressful and there is no change in depressive symptoms. In the context of the USA, white men, who may not have faced racial discrimination in the workplace or other psychosocial stresses that come with being a minority, may move to retirement with less concern for their financial future than African American men. More research, particularly longitudinal cohort studies across cultures and across the lifespan, would help to build a detailed understanding of such complex relationships.

The strengths of this review include the ability to outline predictors and depressive outcomes across time, and the ability to consider multiple predictors.

Another benefit of reviewing observational studies is that the data are minimally contrived by experimental effects. Further, as the review focused on observational prospective longitudinal cohort research, it shares the reliability associated with such studies. Another strength of the review is that the BDI does not rely on diagnostic criteria of depression. Although the inventory is a self-report measure, the results do not apply only to cases of diagnosed depression, but to incidence or change in depressive symptoms more broadly.

3.5.1 Limitations

This review has some potential limitations. First, the review was only able to consider articles for review that were published in English and thus may have missed valuable research findings. Second, the search was limited to indexed, peer-reviewed journals and are unable to comment on whether relevant articles may have missed inclusion for these reasons – particularly where there may have been a publication bias if relevant studies have been conducted in developing countries or in disadvantaged regions. Indeed the majority of studies examined were from research institutes in developed countries of North America and Western Europe, and typically included participants from these areas. As the majority of the data come from studies based in Western, affluent societies, this may have particular implications for findings on the relationships between variables such as education or income and depressive outcomes, and such findings may not be globally generalizable. Further, gender-specific results are more likely to be published if a gender difference has been found, potentially limiting the data able to be incorporated into the review. Third, in many included studies, risk factor exposure patterns may have changed during the course of the study – for instance, participants who were non-smokers at baseline did not necessarily continue to be non-smokers throughout and until follow-up. Thus the complexity of such

relationships may not have been captured with this review. Fourth, as only observational studies were included in the review, the results cannot explore whether or not associations are causal. Fifth, this review does not seek to meta-analyze results, and these findings do not account for differences in power between studies. Thus it is important not to over interpret null results. Last, studies were not excluded based on publication date. Thus data from some older studies may be dated. As the aim was to systematically review all observational studies of depressive symptom development in adult men, there were no objective criteria to determine a cut-off date for which studies should be excluded.

3.5.2 Conclusion

The American Psychological Association (2005) has called for more attention to be given to identifying and monitoring danger signs of depression in men; they have stated that in order for better outcomes for men with depression, better communication needs to take place between psychologists, physicians, family members, friends and employers. This can take place if all concerned have the understanding to identify potential signs of depression and to steer men to effective treatment. This review is part of an increasing body of research that is highlighting risk factors and issues relating to depression specific to men. The results, although preliminary, have already highlighted a range of factors potentially associated with depression that may be of interest in clinical or health promotional settings. As there are growing numbers of community-based programs that are targeting men with depression, a more detailed knowledge of factors related to depression in men is important to enable these programs to be successful. Previous research has prioritized the need for better understanding of how men make sense of their experiences of depression (Ridge, Emslie, & White, 2011). Based on the several inconsistent findings of our research, we also recommend

exploration of the experiences and perspectives of men and their accounts of depression to help explain how and why these factors impact upon their depressive symptoms.

Chapter 4

“We've got to break down the shame”: Portrayals of men’s depression

Statement of Authorship

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Author Contributions

By signing the Statement of Authorship, each author certifies that their stated contribution to the publication is accurate and that permission is granted for the publication to be included in the candidate's thesis.

Name of Principal Author (Candidate)	Brett Scholz		
Contribution to the Paper	Collected data, performed analysis, produced manuscript, and acted as corresponding author		
Signature		Date	

Name of Co-Author	Shona Crabb		
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4.1 Abstract

News articles play a role in reproducing or challenging stigma. Stigma, in turn, can be a barrier to men's mental health help seeking. We used discursive analytic principles to analyze portrayals of men's communication about depression in news articles over a five-year period. We found that news articles depicted men who were open about depression as experiencing positive outcomes such as recovery. Such depictions might challenge stigma associated with talking about mental health concerns. However, some articles problematically positioned depressed men as individually responsible for defying stigma and achieving recovery. We suggest that portraying depression as something that impacts on a plurality of men is one way that media messages might dispel stigma. We drew recommendations from the findings about the language that could be used by media, mental health campaigns, and health service providers to mitigate the impact of stigma on men's mental health help seeking.

4.2 Introduction

Gender roles have been said to influence responses to, and displays of, emotional distress (Addis, 2008). In particular, Addis (2010) argued that masculine norms reinforce stoicism and avoidance of displays of negative affect. The dominance of these norms might contribute to negative consequences for men with depression. This is why men are thought to react to depression by avoiding it, numbing it, escaping it, turning to anger, self-harm, or suicide (Brownhill, Wilhelm, Barclay, & Schmied, 2005). Depression is possibly under-diagnosed in men because they might engage more in these responses than in help seeking (Addis, 2008). This could be one reason, for example, why men are only half as likely as women to be diagnosed with depression (Kessler, 2000), but are four times more likely to commit suicide (Australian Bureau of Statistics, 2010b).

Johnson, Oliffe, Kelly, Galdas, and Ogradniczuk (2012) found that men were reluctant to seek help for mental health problems. One way that men would justify mental health help seeking was by claiming it was done out of desperation. A potential reason for this is related to the stigma attached to men displaying vulnerability. Indeed, men describe health care service use in terms of vulnerability and embarrassment, because of the stigma of accessing mental health services (Jeffries & Grogan, 2011).

Stigma refers to the process of labeling, separating and stereotyping particular groups, leading to status loss and discrimination for group members (Link & Phelan, 2001). Stigma operates on two levels. First, a social level – in which prejudice against a stigmatized group is endorsed publicly – and second, a private level – in which individuals internalize socially endorsed stereotypes (Corrigan, 2004). Stigma has been cited as the largest barrier to mental health care (U.S. Surgeon General, 1999).

The relationship between stigma and men's mental health is complex. For men's mental health, the diagnostic criteria for depression and the act of seeking help for

depression might be thought of as culturally feminized (Kilmartin, 2005). Men who have internalized such stigma, and perceive men who seek help for depression as feminine, might be less likely to approach someone about their mental health concerns (Corrigan, 2004; Courtenay, 2000). Furthermore, individuals who reported in a questionnaire that they believed others held stigmatizing views about help seeking for depression (and those who had internalized these views) were also less likely to seek help from health professionals (Barney, Griffiths, Jorm, & Christensen, 2006). Research from Aromaa and colleagues (2011), however, suggests that stigma will not be a barrier to mental health help seeking if men think their depression is serious enough and if they have sufficient knowledge about treatment. Thus stigma appears to dissuade some men from accessing help for mental health concerns even though it does not stop all men.

Previous research has suggested that the media perpetuates misconceptions about mental illness (Francis et al., 2005; Klin & Lemish, 2008; Nairn, 2007). For example, the portrayal of negative images of mental illness might lead to impairments of self-esteem and self-image in those experiencing poor mental health (Stuart, 2006). Because negative images potentially perpetuate stigma attached to mental illness, they might impact on how those with mental illness are seen and treated by others (Klin & Lemish, 2008). Stigma might inhibit men experiencing mental illness, not only from help seeking, but also from medication adherence, impeding their recovery (Corrigan, 2004). Negative images in the media might, therefore, reproduce stigma on a social level and add to the degree to which individuals internalize stigma around mental illness on a personal level.

Norms about gender are reproduced throughout news and popular media – for example, portrayals of masculinity often emphasize health and fitness (Pompper, 2010), with men who exhibit these characteristics embodying the most celebrated kinds of masculinities. Theorists of hegemonic masculinity conceive that a hierarchy of

masculinities exists, which works to maintain the dominance of particular men over others (Beasley, 2008). In such models, norms of masculinity position men in relation to multiple culturally sanctioned concepts of locally celebrated kinds of masculinities (Bartholomaeus, 2012; Davies, 2003). These norms do not necessarily refer to any particular man, but construct and position men through discourse (Wetherell & Edley, 1999). In the hierarchical structure of masculinity, subordinate masculinities are often those that are similar to femininity (Schippers, 2007). For example, gay men have been positioned at the bottom of the hierarchy of masculinity (Schippers, 2007), and ill men are lower on the hierarchy than healthy men (Courtenay, 2000).

One culturally endorsed assumption of gender is that men do not want help even when necessary (Courtenay, 2000), and another is that men are expected to exhibit good health (Farrimond, 2012). Hence men not in good health who seek help for their problems are doubly marginalized – first for having a health problem, and second for seeking help for the problem. Indeed, according to Charteris-Black and Seale (2009), dominant masculine norms may be responsible for some men being unprepared for distress. These men appear to struggle with their beliefs that they are supposed to act in a masculine manner while undergoing what is perceived by some to be a feminine experience. In focus groups, men and women reported that rather than being open about problems with depression, men will avoid it, numb it, escape it, get angry at themselves and others, self-harm or even suicide (Brownhill, Wilhelm, Barclay, & Schmied, 2005). These behaviors might be more in line with hegemonic masculine ideals than help-seeking behaviors.

There do appear to be changes in the way that depression is being discussed in relation to masculinity. Anderson and Kian (2012) theorize that a cultural shift is occurring such that what they refer to as “softer” masculinities might be increasingly valued, and that media messages might be reflecting these changes. Support programs

designed to encourage men to access help for depression have been increasing (for some examples see *beyondblue*, 2010). Other campaigns have also been produced to bring attention to the social construction of masculinity and its role in mental health (such as *Spur Projects*, 2012).

The past five years have marked significant changes in men's mental health promotion in Australia (Jorm, Christensen, & Griffiths, 2006). In 2006, *beyondblue*, an Australian organization whose aim is to increase awareness of depression and related disorders, partnered with a global movement that runs annual campaigns in aid of improved health outcomes for men, and began sponsoring the *beyondblue Cup* – an annual event raising awareness of depression at a game of the popular Australian Football League (*beyondblue*, 2007). Even though sporting events such as these might appeal only to a certain group of men, the use of such events to raise mental health awareness suggests a shift in how mental health campaigns are being presented. Such initiatives serve to raise the public profile of depression in general and its impact on men in particular. Thus the coverage of men's depression in news media across Australia increased throughout this period, offering much material for analysis.

Media messages are powerful influences and resources (Seale, 2002). Media representations of knowledge, experiences and discourses are significant to our understanding and become integrated into our everyday experiences and activities (Halkier, 2010). Media representations of medical conditions and health issues influence individuals' subjectivities because they create, reproduce and affect attitudes toward illness and those living with illness (Lyons, 2000). For example, if men are exposed to certain discourses about masculinity and mental health throughout their life, it will potentially impact on how these men think of themselves in relation to mental illness, how they communicate with others about mental illness, and their attitudes in regards to mental health, help seeking, and others who approach them with mental

health concerns. Despite increased advocacy for mental health concerns, research has found that media might be continuing to label and dehumanize the experience of mental illness (Vahabzadeh, Wittenauer & Carr, 2011).

There has been little research specifically focusing on media portrayal of men's experiences with depression. A study by Bengs and colleagues (2008) found that Swedish newspapers' portrayals of men with depression were less emotional and expressive, and reported more sudden onsets of depression, than portrayals of women with depression. This was seen to reflect broader hegemonic patterns of masculinity in relation to distress. Similarly, blog entries by depressed men, when compared with those of depressed women, were reported to involve more bio-medicalized explanations of distress, focus more on world events and their impact on distress, less on personal or relationship events, and more frequently involve violence (Clarke & van Amerom, 2008).

Research suggests that portrayals of depression in the mass media might reproduce stereotypical concepts of hegemonic masculinity (Clarke, 2009). In particular, the reproduction of the idea that men should not express feelings and should not seek help for problems related to their feelings might serve to reinforce stigma. Men constrained by stigma could be less empowered to access information and seek direction when they experience difficulties with their mental health and wellbeing. Nairn and Coverdale (2005) argue that although few, there are also positive messages about mental illness in mass media, and that research attention should be given to the depictions and the voices of people with mental illness in mass media.

As media depictions of men's experiences with depression shape attitudes toward men's mental illness, and how men make sense of their own experiences with depression, this article aimed to analyze these depictions, in line with the call for research to focus on men's subjectivities and the meanings accorded to distress (Ridge,

Emslie, & White, 2011). Furthermore, this article focused on Australian news media sources because of the increase in portrayals of men's depression in the Australian media in recent years.

4.3 Method

The data for this analysis came from news articles about men's communication about depression. All media articles analyzed are publicly available. Although approval from an ethics committee is therefore not necessary, we have taken measures to perform this research in an ethical manner. We have ensured that data used are not defamatory against particular individuals, and we have taken care not to reproduce stigma but to draw attention to it for critical debate.

The Factiva database aggregates journalistic and business publications from across the world. Given the change in how depression and mental health have been portrayed in Australia in recent years, we searched Factiva's database for all Australian articles in major news or business publications in print or online form indexed under the "depression" subject heading. Factiva's subject headings have become increasingly sophisticated, thus this search could be expected to return articles most relevant to the topic of depression (Sykes, 2011). In line with the aforementioned increase of media attention to depression over the past five years, we sourced articles from the period from September 1, 2006 to August 31, 2011. This search yielded a total of 849 print and online news articles.

The first author read all articles, and selected for additional investigation all articles making specific reference to a man with depression or men's experiences of depression. This process resulted in 702 articles for more analysis. Initially, we utilized a thematic analytic method (Braun & Clarke, 1996) to observe and record meaningful patterns across the 702 news articles that we had collected. The thematic analysis of the

data set involved reading of all 702 articles and initial noting of salient patterns across articles. From these notes, we produced data-driven codes and read through the articles again, applying our initial codes where relevant. The next step was to sort these codes into potential themes. One of the salient and theoretically relevant themes that was produced through this process related to ways in which men were portrayed as being or not being communicative about depression.

To engage in an in depth exploration of the meanings of this theme of communication, we adopted an analytic approach informed by discursive psychology principles (Edwards & Potter, 1992; Potter, 1996). These principles are constructionist and posit that discourse does not only describe occurrences, but can also be used to perform actions and achieve goals. Potter (1996) established that analysis rooted in discursive psychology is concerned with how the construction of text or talk conveys subjective meaning. We applied discursive psychological principles in our analysis to focus on the constructions of depression and men produced by news articles and to describe how the articles work to reject or reproduce the stigma of men's depression.

Our analysis focused particularly on the interpretative repertoires that news articles draw on to explore how depression itself is constructed. Interpretative repertoires are discursive resources which are understood by a community that comprise specific terms, features, or metaphors (Edley, 2001). A given text might draw on particular interpretative repertoires to construct individuals or situations in schematically understood ways. Our analysis was also concerned with the repertoires drawn on in news articles to position individuals as responsible (or not) for mental health.

4.4 Findings

In our analysis, we focused on two major, interrelated features of the data about men's communication about their depression. The first related to how positive outcomes were portrayed as a consequence of men being communicative about depression, and the second was concerned with who is positioned as responsible for defying the stigma associated with being open about depression. Extracts presented in this section were chosen because they are representative of these two features of the data corpus. We argue that representations of men's communication about depression in the media might work to reduce stigma around men's mental health help-seeking behaviors. This is particularly the case for those accounts which emphasize positive outcomes associated with men being communicative of depression. We also note that it is potentially problematic to position depressed men as individually responsible for defying stigma and communicating about depression, thus drawing attention away from the social forces that work to create such stigma.

4.4.1 Communication constituting positive outcomes

In the news articles analyzed, being open about experiencing depression (often referred to as being "out") was dominantly constructed as a positive way to deal with depression. Talking openly about these problems was often an important step toward recovery from depression (sometimes referred to as being "free"). For example, Extract 1 presents the story of Andrew Robb, a prominent Australian Member of Federal Parliament who had made public announcements about his experience of depression. This extract comes from *The Australian*, which is the highest-selling national newspaper, available in each state and territory of Australia.

This extract provides an instance in which announcing one's depression is represented as a step toward recovery. Continuing to communicate about these

problems – in this example, publishing a memoir – is portrayed as the next part of the recovery process (“Today he took *another* step forward in his recovery,” lines [L] 4-5, italics added). Robb is presented as saying that this memoir will “rid him of one more demon or two” (L7-8). This construction is particularly remarkable as the act of being communicative itself is portrayed as the agent of Robb’s recovery. The argument that openness would aid recovery and deal with demons is not questioned.

This article positions Robb as helping himself and perhaps other men move toward being more communicative and therefore toward recovery. It does so by implying that through raising awareness, Robb’s openness about depression encourages men to tell “the boss or their mates” (L16). The suggestion to tell a boss or friends about problems with depression challenges the ideal of hegemonic masculinity that men would not discuss issues that could make them seem weak. If this message can help to reduce the stigma against men being open about depression, such a portrayal might be a step toward allowing more men to seek help should they so choose.

Extract 1¹

Australian Associated Press (2011)

1 Mr Robb, the shadow finance
2 minister, revealed publicly in
3 2009 that he suffered from
4 depression. Today he took another
5 step forward in his recovery from
6 the illness by launching a memoir

¹ The formatting of these extracts may appear strange, as they have not been changed from the version published in *Qualitative Health Research*. This has been done to preserve the same line numbers.

7 he says will rid him of one more
8 demon or two. . . .² In his book Mr
9 Robb acknowledges there are many
10 with worse depression and in
11 worse circumstances than him. But
12 all of them need the sort of help
13 he received. "There are still
14 hundreds of thousands of people,
15 especially men, who can't tell
16 the boss or their mates because
17 they fear the stigma," he said . . .

Extract 2 deals less with positive outcomes in a personal sense, instead pointing to how being open about depression could reduce stigma and enable positive outcomes in others. The extract comes from an article that appeared in *The Advertiser*, South Australia's major newspaper.

Extract 2

Littley (2011)

1 . . . Adelaide ride director Boyd
2 Stuckey, who suffers from depression,
3 said the event helped raise awareness
4 of depression and reduce the stigma
5 of it. "There's still a lot of

² In these extracts, ". . ." indicates that the original text has been abridged.

6 misunderstanding about depression,”
7 he said. “It doesn’t discriminate. It
8 can affect anyone and the ride is a
9 good way of showing that.”

The article states that Boyd Stuckey “suffers” (L2) from depression. Stuckey is not a public figure yet he is still represented as taking it on himself to raise awareness to allow other depressed men to be able to talk about their depression. Although he is not represented as explicitly communicating about his own depression in this article, he is shown as being open about his depression. Stuckey’s quotes construct depression as a condition that potentially impacts on any man (“It doesn’t discriminate. It can affect anyone,” L7-9). Construction of depression as a condition that can happen to anyone challenges stigma surrounding men’s openness about depression. If media articles on depression continue to focus primarily on celebrities with depression (Clarke, 2009) or on depression as a form of madness (Nairn, 2007), the differences between most men and those portrayed as being depressed remain significant, potentially reinforcing stigma.

Media pieces such as the one presented in this extract could work to combat stigma as they empower men to have their voice heard, and actively demonstrate that depression is not something that happens only to “mad” people. Many of the media articles forming the data corpus for this current study were about high-profile men, particularly Members of Parliament or lawyers (such as in the Extract 1). Although we do argue that such portrayals of high-profile men being open about their depression could help to reduce the stigma against men’s depression, these portrayals could also reproduce hierarchies of masculinity and construct communication about depression as something that only stereotypically successful men can do. We would suggest that a

broader range of men's stories could function to empower even more men. As Adichie (2009) suggests, knowing only a single story about a group of people reinforces stereotypes and perpetuates stigma. Showing that depression occurs in a plurality of men is one way that media might dispel stigma.

In the news articles we analyzed, representations of men not being communicative or open about their depression typically involved poor outcomes. We suggest that these constructions also serve to highlight that men's openness about their depressive symptoms is important in their being able to achieve positive outcomes, as in Extract 3, which also comes from *The Advertiser*.

Extract 3

Schriever (2011a)

1 . . . In a eulogy read yesterday by
2 Tony Monte Funeral services celebrant
3 Wendy Alland, Trevor's family said
4 his struggle with depression meant he
5 was unable to "recognise his own
6 worth". They said he turned to
7 alcohol, and would not tell his
8 family about his problems "for fear
9 of worrying them". "He was a totally
10 different person and unrecognisable
11 when he had been drinking," Ms Alland
12 said . . .

In this extract, Trevor is portrayed as having turned to alcohol instead of opening up and discussing his depression. Notably, his turn to alcohol is constructed as having led to him becoming a “totally different person” (L9-10). Portrayals of loss or change of identity as a result of being uncommunicative were a feature of many news articles, often with a family member stating that the individual acted in ways unrecognizable from their normal behavior. This extract exemplifies how articles about men not being open about issues with depression also function to reinforce that being communicative will lead to recovery or improvement for the depressed man.

4.4.2 Positioning of responsibility

Media representations depicting men being open about depression could help to challenge stigma against men being communicative. We note, however, that such messages are potentially problematic. This is because these representations could position depressed men as individually responsible for being communicative and, in turn, for the outcomes of their depression. In the Extract 1, for example, Andrew Robb begins his recovery from depression by revealing it publicly (L2), then takes “another step forward in his recovery” (L4-5) by launching his memoir. He is constructed as actively taking steps to alleviate his depression, through the act of communicating about the condition. Arguably then, this representation serves to position depressed men as needing to engage in communication, and to be open about their depression, to begin their recovery journey. The responsibility for recovery, therefore, is constructed as lying with the men themselves.

Similarly, in Extract 3, Trevor Cologne is said to have “turned to alcohol, and would not tell his family about his problems for fear of worrying them” (L6-9) and was described as a “totally different person and unrecognizable when he had been drinking” (L9-11). Implicit in this construction is the suggestion that if Trevor had told his family

about his problems, his turn to alcohol and his transition to a “different,” “unrecognisable” person might have been avoided. Thus in the typical narrative of depressed men’s communication, as seen in the media articles analyzed here, it is the depressed man himself who is positioned as responsible for being open about depression to begin recovery, and thus for defying stigma.

Some media articles provided alternative positionings of responsibility. These were, however, also potentially problematic. For example, Extract 4 constructs a lack of communication as contributing to a risk of suicide, and exemplifies the tension between positioning men as primarily responsible and positioning others as responsible. This extract is taken from an article published in *The West Australian*, the major newspaper of Western Australia.

Initially in this extract, “a man with depression” (L2) is presented as “[feeling] better” (L4) if he is open about his depression and seeks “help from a doctor” (L1). The man himself is positioned as having responsibility for communicating about his depression and getting help. Men who do not communicate are constructed as facing negative outcomes (“if depression is denied or ignored, problems can continue for years, with a greater risk of suicide,” L5-8).

As well as depicting men with depression as needing to communicate, this extract also demonstrates how other individuals (often women in the media articles analyzed) can be positioned as more concerned with men’s health than men themselves (“women can help by getting depressed men to a [general practitioner],” L8-10). This construction is potentially problematic as it includes an implicit assumption that men’s mental health outcomes are (at least partly) dependent on women.

Representations of women in several media articles in our data appeared to reproduce the discourse of women as responsible for others’ health (discussed in detail by Lyons & Willot, 1999). Note that the women referred to in L8 of the extract are not

explicitly stated to be men's significant others, yet the repertoire does seem to draw on an implicit assumption of heterosexual partnership, such that women should take some responsibility for their heterosexual partner's mental health (ignoring men not in relationships with women). Regardless of whether it is a significant other (or simply any other woman) implied by this extract, there remains another underlying assumption that women can sense a man's depression even in cases where "depression is denied or ignored" (L5-6). Such a statement almost suggests a moral expectation that women should monitor the mental health of men in their lives, and implies that women have insight into or surveillance over men's mental state.

Extract 4

"Why Seek Help?" (2007)

1 . . . If help from a doctor is sought
2 early, a man with depression will
3 find his mood lifts and he feels
4 better after a few weeks or months of
5 treatment. If depression is denied or
6 ignored, problems can continue for
7 years, with a greater risk of
8 suicide. Women can help by getting
9 depressed men to a [general
10 practitioner] or local mental health
11 service. Tell loved ones you can see
12 when they are unwell and they must
13 talk to someone about it. Often a

14 depressed male has tunnel vision and

15 cannot see help is needed.

The reproduction of such discourses is additionally problematic in that it positions men as ignorant of their own mental health and in need of assistance (“often a depressed male has tunnel vision and cannot see help is needed,” L13-14). The assumption being portrayed is that men will not talk about problems, and that they are deficient if they do not do so (because they are portrayed as needing “help” (L14) to get to the relevant health professionals). As in the work of Seymour-Smith, Wetherell and Phoenix (2002), such representations construct men as childlike and in need of assistance, which might additionally challenge depressed men’s masculine ideals. Thus, even though we have argued that positioning men as the sole agents responsible for defying stigma and openly communicating about depression might be problematic, we add that the assumption that women in their life (particularly significant others) should be responsible might also be problematic.

Extracts 5 and 6 represent cases from our corpus that deviate from the typical positioning of depressed men as individually responsible. Each of these extracts suggest that it is not only men – or their heterosexual significant others – who should be held accountable for being open about depression. Extract 5 tells the story of an individual who kept his condition private and who committed suicide after years of depression. Even as he contemplated suicide he wrote to his parents asking them to make no announcement of his death and to have a small, private funeral. In the article, his mother discusses the responsibility that ‘we’ all have to defy the stigma surrounding men’s mental health problems.

Similar to the first four extracts, Extract 5 constructs communication as vital to preventing negative outcomes for depressed men. It also comments on men being

unable to be communicative about such issues because of stigma. Statements such as “people who are depressed do anything to mask their symptoms” (L16-17) were common in our data corpus. Such statements suggest that if a depressed man is doing all he can to mask his symptoms it cannot be known that he needs help (particularly problematic if heterosexual partners are to be held accountable for monitoring their mental health as in the fourth extract).

Extract 5

Legge (2011)

1 . . . The Jepsens made an
2 announcement at their local church,
3 where concern was expressed about
4 whether Tristan could go to Heaven.
5 “It was a shock for the community but
6 it gave people permission to talk
7 about it,” Marie says. “When everyone
8 is hiding from it, then that is a
9 really tragic thing. There is so much
10 Ignorance out there.” The Jepsen
11 Family set up a foundation in honour
12 of Tristan, with a special focus on
13 educating the legal profession about
14 depression in its ranks. “We’ve got
15 to break down the shame,” says Marie.
16 “People who are depressed do anything

17 to mask their symptoms. We should be
18 out there telling people that if
19 someone around you says they are
20 thinking of committing suicide, don't
21 Ignore it. Call an ambulance. Take
22 them to emergency. If we help one
23 person it will be worth it."

Some articles (such as those represented in Extracts 3 and 4) position men as responsible for negative outcomes arising from not being communicative about their depression. Extract 5, however, exemplifies the difficulty others might have when faced with the possibility of a man in their life experiencing depression. This portrayal holds other individuals and, more broadly, society to account to take responsibility for men's depression. This is achieved by emphasizing the need for surveillance of depressive symptoms, the importance of taking up communication with men who choose to talk about their depression, and the necessity of removing stigma against such communication ("we've got to break down the shame," L14-15). Men who have internalized public stigma are less likely to access mental health services (Corrigan, 2004; Courtenay, 2000). Media articles such as the one in this extract might therefore work to challenge the stigma of men's depression by constructing other individuals as responsible for attitude change.

Extract 6 presents a story about a depressed man who eventually committed suicide in spite of attempts to be communicative. It provides a relatively rare example of the construction of openness about depression as not necessarily leading to positive outcomes. It positions depressed men as not solely responsible for such outcomes and demonstrates the importance of reciprocal communication.

In this extract, Cologne's communication attempts were not a step toward recovery. Instead, his problems are suggested to have led to him committing suicide. This was one of very few articles that did not portray communication in relation to depression alleviation or recovery. This article constructs the responsibility for getting better as not belonging exclusively to men, but that others must listen to respond. This constructs openness and communication as not necessarily sufficient to resolve problems with depression and portrays positive outcomes as a product of not only successful communication, but suggests there must be another party listening to the problem and willing to help. This shifts the focus of responsibility for challenging stigma from the individual depressed man to a broader social issue. Removing the public stigma of men's depression brings depressed men a step closer to being able to seek help should they so choose.

Extract 6

Schriever, (2011b)

1 . . . When he called the Assessment
2 and Crisis Intervention Service for
3 help, he was often drunk and would be
4 referred to the police. . . . In the
5 hours before his death, Mr Cologne
6 Pleaded for help through social
7 networking site Facebook. Among a
8 Series of harrowing posts, he wrote:
9 "No job, no girl, no house, no car,
10 no money, no friends, no life, no

11 point.” One of his final posts read:

12 “F....g (sic) help me.”

4.5 Discussion

We found that many news articles portrayed men who were open about their depression as experiencing positive outcomes (such as recovery). We suggest that such depictions might challenge stigma associated with men talking about mental health concerns. We also found some depictions of men were potentially problematic. Specifically, those that position individual men as responsible for defying stigma and achieving recovery were critiqued.

This study is limited in terms of the scope of the data because of the focus on only Australian news articles, and also only on articles published over a five-year period. Nonetheless, this context was chosen as there was an increase in the relevant media coverage during that period in Australia. Discourses of men’s communication about depression were present in internationally as well as locally distributed media. Thus although this analysis is concerned with representations of men’s communication about depression in Australian news media, some issues are likely to relate to broader discourses of masculinity. Connell and Messerschmidt (2005) discuss some of the ways in which hierarchies of masculinity are present in global contexts. We argue that our findings may be relevant to international contexts in which hierarchies of masculinity and mental health stigma are present.

Vahabzadeh, Wettenauer and Carr (2011) emphasized the importance of media as a force capable of reducing stigma against mental illness. They suggested that advocating for journalists to consult mental health professionals in reporting about mental illness could lead to more accurate perceptions, less fear, and better social

awareness of mental illness. Our results expand on this, making suggestions about ways in which media can challenge stigma around men's depression.

First, we suggest an increase in the number and diversity of portrayals of men communicating about and seeking help for depression could reduce stigma. This article has spotlighted some more positive messages about mental illness. Previous research found media portraying depression as madness (Nairn, 2007) or as primarily affecting successful men and potentially marginalizing most men (Clarke, 2009). Even though these features were present in our data (there were several articles about MP Robb, for example), and media will produce articles about high profile individuals, we found an emerging presence of other messages about depression. This included media giving a voice to depressed men without a public profile, and the media focusing on articles about being open and communicative of depression. Such portrayals of depression as something that could happen to any man and as something any man can be communicative about challenge hegemonic norms of masculinity. Challenging these norms might lead to a shift in the stigma attached to depression and mental health help seeking.

Second, the implicit assumption that heterosexual significant others should engage in surveillance of men's mental health and should be responsible for men's help seeking (as in Extract 4) was also problematic. This finding reflects research by Seymour-Smith and colleagues (2002), who reported that health professionals, in their talk about men's help-seeking behaviors, reproduce normative discourses about women as health conscious (and therefore responsible) and men as not. The authors concluded that health professionals' positioning of men was paradoxical – men were respected for stoicism and for only attending surgery when necessary, but at the same time men were of concern because they did not take responsibility for health. Thus men's health was often seen as women's business, with problematic implications for health promotion for

men without heterosexual partners. This current study extends this finding specifically to mental health, finding similar representations in news media.

Last, instead of reproducing patterns of talk marginalizing men outside of heterosexual partnerships and endowing women with responsibility for men's health, the media could be a site helping to shape "discourses that . . . reinforce the positive ways in which men are caring for themselves" (Johnson et al., 2012, p. 358). Our research findings propose that some news articles do reinforce men caring for themselves in positive ways, but that there are also some articles with problematic implications for men's mental health help seeking. These findings have implications for the provision of health services and the delivery of health promotion materials. Such services and materials could be successful should they emphasize the importance of stigma change and challenge discourses that reproduce problematic constructions of the responsibility for defying stigma. A public health campaign targeted at challenging stigma on a public level could reduce the extent to which men internalize stigmatizing thoughts about masculinity and depression, and might lead to more men accessing health services.

4.6 Conclusion

Our analysis has discussed ways in which Australian news media portrayals of the way depressed men communicate challenge and reproduce stigma associated with men's mental health help seeking. Whether portrayals of communication about depression are similar across other media – such as television programs, magazines, online media, or health promotion material – might be of interest to researchers. Future research might also consider a focus on how men make sense of communication and mental health help seeking, or on how men resist stigmatized subject positions when communicating about their depression.

Chapter 5

“Males don’t wanna bring anything up to their doctor”:

Men’s discourses of depression

Statement of Authorship

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5.1 Abstract

Men who are experiencing depression may present with a range of externalising behaviours. These include avoidance, getting angry, or finding distractions rather than seeking help. General practitioners have reported that depression is harder to diagnose in men than it is in women. Men's experiences of depression are not widely understood as research has not typically focused on men's accounts of depression. The aim of the current study was to explore ways in which men discuss depression with particular focus on how masculinity, comorbidity, and external factors impact men's subjectivities of the condition. A thematic analytic framework informed the analysis of interviews with men who had experienced high levels of depressive symptoms. Two overarching themes are discussed. The first relates to links between depression and health, including comorbid physical illnesses. The second relates to the social context in which depression is experienced. These findings extend upon previous research that suggests medical practitioners have difficulty with competing biomedical and social discourses of depression, highlighting the importance of continuing to improve understandings of men's depression discourses.

Keywords: depression; masculinity; men's health; thematic analysis

5.2 Introduction

Disproportionately fewer men are diagnosed with and treated for depression than women (Branney & White, 2008). Addis (2008) suggests that one explanation for this disparity could be that masculine gender norms encourage action rather than introspection – such that men who are depressed exhibit externalising symptoms (such as avoidance, or getting angry). Depression is sometimes seen to be socially constructed as a feminine problem, and thus denying depression is one way that men might enact masculinity (Schofield, Connell, Walker, Bed, & Butland, 2010). Furthermore, it appears that men tend to rely on somatic cues in appraising bodily symptoms (Barsky, Peekna, & Borus, 2001), which might lead to different diagnoses in men and women for the same condition.

Another factor that may impact upon the disparity in men's and women's diagnosis of depression is that the medical system could be thought of as “gender blind” (Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012, p. 346). This theory suggests that diagnosis for depression relies on criteria insensitive to gender differences in the display of and response to depressive symptoms (men may present with only multiple somatic complaints, for example). General practitioners (GPs) report that depression is more difficult to diagnose in men than in women, and perceive these difficulties to be a result of men either being unable to, or choosing not to discuss emotional concerns (Lyons & Janca, 2009). Research suggests that men may not volunteer information but will express health concerns if communication is appropriately facilitated (Zaman & Underwood, 2003). To better understand how beneficial communication can take place, researchers have called for a greater understanding of men's experiences of distress (Ridge, Emslie, & White, 2011).

One way in which research has started to build better understandings of men's experiences of distress is through a specific focus on depression in men, however,

research with a focus on men's accounts of their own depression remains sparse (Addis, 2008). Ridge and colleagues (2011) discuss the importance of exploring men's subjectivities in their work, emphasising that men's subjective lives have been neglected in health research.

There has been emerging research exploring gendered subjectivities of different aspects of depression (Johnson, Oliffe, Kelly, Galdas, & Ogradniczuk, 2012; Lafrance, 2006; Oliffe et al., 2010; Rice, Fallon, & Bambling, 2012). Building on the idea that men will engage in their own health care (Smith, Braunack-Mayer, Wittert, & Warin, 2008), Johnson and colleagues (2012) reported that depressed men explained their mental health help-seeking in particular ways. Some participants' accounts challenged dominant ideals of masculinity, instead emphasising the role of help-seeking in being understood and having illness validated by a professional. Most accounts, however, included typically masculine explanations of help-seeking, such as only engaging with health services out of necessity. It appears that depression may impact on men's subjectivities about what it means to achieve masculine ideals.

Not being able to achieve masculine ideals can lead to distress which, in turn, triggers depression (Oliffe et al., 2010). Syzdek and Addis (2010) found that of a diverse group of unemployed men, those who identified most strongly with masculine norms were more likely to develop depressive symptoms. Galasiński (2008) spoke to men who identified as depressed about their condition, and found that men tend to distance themselves from their depression, and that expectations of masculinity are responsible for an uneasy relationship between men and their depression. Men in Galasiński's study talked about themselves as being outside of their depression. This was achieved through the use of strategies such as: (1) choice of impersonal pronouns; (2) speaking about their depression from an outside or observer's perspective; and (3) undermining and belittling the depression itself. This work provides an important

insight into some of the discursive strategies that allow men to retain masculine subject positioning while talking about their concerns about depression. Much remains unknown about men's subjectivities of depression.

Furthermore, factors related to the incidence of depression in men are also not yet well understood. For example, in a systematic review of factors associated with the development of men's depressive symptoms, Scholz, Crabb and Wittert (2013) found several aspects of men's depression not yet well understood by current research. For instance, the findings of some studies suggest that social support is not related to the development of men's depressive symptoms (Coventry et al., 2009), while others suggest that greater social support is associated with fewer depressive symptoms (Huurre, Eerola, Rahkonen, & Aro, 2007). Different ways in which individual studies operationalise measures of social support may also lead to different research outcomes (Scholz, Crabb & Wittert, 2013). To better understand how men make sense of diverse biopsychosocial factors including comorbidities and stress, an aim of the current study is to explore issues men raise as relevant to their depression narratives.

To increase understandings of men's subjectivities of depression, and to work towards the call from Ridge et al. (2011) to enrich understandings of men's experiences of mental distress, the current study aims to explore what issues men orient to as important in their depression narratives. The participants in this study were not specifically asked about depression until they raised it themselves in an interview setting. To expand on current understandings of men's experiences of depression, particular attention will be given to ways in which concepts of masculinity and health are deployed in discussions of depression.

5.3 Method

5.3.1 Data collection

The study was approved by The Royal Adelaide Hospital Research Ethics Committee. Participants were drawn from the Florey Adelaide Male Ageing Study (FAMAS), a longitudinal cohort study of men living within a catchment area in the North-West of Adelaide, Australia. Baseline FAMAS assessments commenced in 2002 and were followed by annual questionnaires (Martin, Haren, Taylor, Middleton, & Wittert, 2007); a second wave commenced in 2010. To be included in the study, men had to have experienced a high level of depressive symptoms. Therefore, participants for the current study were randomly selected from those in the FAMAS sample who had scored within the highest quartile of depressive symptoms as measured by the Beck Depression Inventory (BDI) (Beck, Steer, & Carbin, 1988). As such, participants did not necessarily have high depressive symptoms at the time of interview, nor were they necessarily aware that they had scored highly on the BDI.

Twenty-four participants were invited to participate in an in-depth interview, and ten agreed to take part.

At the time of the interviews, one of the participants lived in regional South Australia. All other participants were living in urban or suburban Adelaide, South Australia. The participants' ages ranged from 45 to 88, with most participants in their 40s and 50s. Three participants were living with partners, one lived alone but was partnered, and six were single. Two participants were retired, one was unemployed, and seven were employed.

The interviews comprised of broad, open-ended questions. Informed consent was gained prior to each interview. Interview questions were not explicitly related to depression, as we were interested in how participants would discuss features of their

depressive symptoms in a conversation more generally focused on health, stress and coping. Informed by advice about interviews with men about health from Ollife (2005) and Galasiński (2008), the interviewer placed importance upon allowing participants to drive the extent of rapport building within each interview. Some interview conversations deviated from the interview schedule, as participants were free to orient to features of their experience that they deemed important. The shortest interview lasted 10 minutes, while the longest lasted 98 minutes. The majority of interviews took between 30 and 50 minutes. Interview recordings were orthographically transcribed for analysis, using pseudonyms for participants and any individuals mentioned, and removing potentially identifying information.

5.3.2 Data analysis

To identify, analyse and draw meaning from themes within the interview data, we employed a thematic analytic framework (Braun & Clarke, 2006). The approach adopted was inductive and deductive, constructionist, and focused on the semantic content of the entire data set. Braun and Clarke's (2006) suggestions for conducting thematic analysis were followed: the first author thoroughly immersed himself in reading the data repeatedly and preliminary coding was applied to the whole data set. Each of these codes was searched for similar themes. A map of these themes was produced to elaborate on connections and relationships between or within themes. This map enabled the definitions of each theme to be refined. All authors reviewed the themes collaboratively, refining the definitions and boundaries of each theme. We aimed not only to describe themes but also to interpret the meanings and significance underpinning the themes.

Our analysis also draws on the discursive psychological principle of subject positions (Edley, 2001). This principle emphasises the importance of looking at how

discourses constrain or allow particular identities to be made salient. For example, a narrative about a man with depression may (or may not) make his identity as a man salient, but there are other ways in which a particular man may be positioned in such narratives. These might include his identity as a father, husband, worker, victim of depression, or any other possible affiliation. In our analysis we were interested in how men may negotiate or resist particular subject positions.

5.4 Analysis and Discussion

From our coding, two aspects of men's talk become prominent. The first aspect related to how men made sense of depression in relation to their health, and the second involved talk about external factors associated with their depression. We discuss each of these aspects separately in relation to relevant literature and implications.

5.4.1 Depression in relation to health

There were three themes within the data which related to how men made sense of depression in relation to health. These themes were characterised by participants': (1) discussion of the relationship between physical and mental health; (2) talk about medical health services; and (3) discourses about depression severity.

Theme 1: The relationship between physical and mental health

A theme of the interview data was that depression was commonly talked about in relation to physical health – including how one could lead to the other, as well as the overlaps and differences between them. For instance, one of the ways that physical health was related to mental health in participants' talk was through reporting emotional responses to physical conditions, as in Extract 1. This participant states that he “broke

down” after being told that he was lucky to be alive following several health complications.

Although he does not explicitly mention depression in this extract, this participant clearly conveyed a sense of heightened emotion in response to his physical health outcomes. Lafrance’s (2007) research explored how women with depression may work to legitimise their identities as genuine sufferers of depression. Lafrance argued that in the absence of observable ‘evidence’ of symptoms, those with mental health problems may need to defend the authenticity of their experiences to be accepted as ‘legitimate’ by observers. In addition to the pressure to be suffering legitimately, men are expected to exhibit good health (Lyons, 2009). Taken together, social norms expecting men to be in good health and misunderstandings about unobservable symptoms of depression may compound the pressure men experience to provide observable evidence of their mental distress. In the case of the Extract 1, the participant’s reference to multiple physical ailments (a stroke, a heart attack, and problems with his lungs) works to legitimise his mental distress. It may be easier for men to discuss emotional distress if they can be explained through the presence of observable symptoms.

Extract 1 (Interview 1)

Interviewer (I): Has [emotion] had a big impact upon your health?

Participant (P): Ah yeah when a thing happens like that, you know, the stroke, the heart attack, this thing here (indicating his lungs), and they tell you “by gee you are lucky to be here still” ah you still break down. You can’t help it.

Participants also talked about how physical health problems could impact upon an individual's occupational or social life and, in turn, lead to greater depression. For example, Extract 2 exemplifies how poor physical health can lead to an inability to continue to work, with poor outcomes for the participant's mental health.

Extract 2 (Interview 8)

P: I've got a bad back – sciatica...³ Because I don't work – I'm on a disability pension, the [Department of Veterans' Affairs pension]. And it gets you down. I was working up until '07. I was a male EN nurse diploma and had a bad accident at work – patient [had] a seizure and landed on top of me, I haven't worked since and it gets very depressing not being able to work... I've applied for heaps of jobs. They all say 'yes' but as soon as you mention back problems, that's the last you hear of them.

As the participant in Extract 2 states, “it gets very depressing not being able to work”. His mental health is constructed as being influenced by both his physical injuries and their consequences in terms of his working life. In addition to being precluded from work, participants reported that poor physical health impacted on their social activities, potentially leading to greater depression. For example, one participant talked about how Chronic Fatigue Syndrome was distressing as it prevented him from being social (“I can't go camping with them, they go off to horse events and they camp ... physically I couldn't do that because I need somewhere at the end of the day to sit down you know

³ In the extracts within this study, ellipses indicate that the quote has been abridged to include only that which is relevant to the analysis.

just a comfortable chair or something like that”, Interview 3). These results suggest that greater mental health support could be beneficial during difficulties associated with physical health.

In some cases, depression may be confused or conflated with other complaints. One participant, for example, downplayed his diagnosis of depression and emphasised his diagnosis of haemochromatosis – a condition which can share some symptoms in common with depression such as fatigue and loss of libido (Adams, Kertesz, & Valberg, 1991). The participant drew on information pamphlets about haemochromatosis that suggested that “a lot of people are diagnosed wrongly” (Interview 10) but did acknowledge that he “had a bit of depression at the time [but that the] double whammy of haemochromatosis wouldn’t have helped” (Interview 10). Orienting to a similar physical illness might serve to legitimise comorbid depression. Continued awareness and attention (for both health practitioners and health service consumers) may protect against greater stress potentially arising from depression present in conjunction with other conditions.

This first theme highlights the interface between physical health and mental health, and the related ways in which men understand their depression. While physical health conditions may provide legitimacy to men’s talk about mental health concerns (such as in Extract 1), physical health concerns may confound mental health concerns (such as in the earlier discussion of haemochromatosis in Interview 10). Indeed, the relationship between depression and comorbidities has been discussed by Alexopoulos and colleagues (2002), who emphasise that the recursive nature between depression and comorbidities needs further research attention in order to improve outcomes for patients. Comorbid conditions worsen outcomes for individuals with depression (Moussavi et al., 2007), highlighting the impact of depression on multiple dimensions

of men's health. Men's subjectivities of depression may influence and be influenced by their experience of physical illnesses.

Theme 2: Medical health services

Many participants talked about seeking or using medical treatment for depression. This theme was deployed in two ways: talk about medication needed to manage depression, and talk about masculine norms influencing the seeking of medical help. Both discourses involved constructions of depression as a disorder requiring treatment, thus emphasising the relationship between depression and health.

Talk about medication for depression was common throughout the interviews. Previous research examining women's talk about medication for depression has reported how talk of medication was simultaneously potentially helpful and oppressive to women (Lafrance, 2007). Lafrance (2007) found that talk about medication constructed depression as a biological disease to be treated, which legitimised the distress of depression as 'real'. Talk of medication was found also to be potentially oppressive to women, as medications were constructed as ways for women to be 'better mothers' able to deal with tasks like cooking and cleaning. By positioning distress as a pathology, and glorifying women as naturally inclined to be caring and domestic, talk about medication served to uphold hegemonic discourses of femininity.

Talk about medication for the treatment of depression was a site of contention for participants in the current study, also. Some participants depicted medication use as a non-essential choice, to be made within the context of each individual's experience. This construction challenged the notion of depression as a purely biomedical condition that can only be treated with medication. For example, in Extract 3, the participant presented antidepressant use as something he would have resisted, had it been offered.

Extract 3 (Interview 6)

I: Were you recommended to take antidepressants or anything like that?

P: No, we didn't actually have that conversation. Which is fine by me because I would have said no to that anyway. I used to work with someone at the last place I was working at teaching at and a lady there – who was also a depression sufferer – would be on medications teaching and stuff like that. That was an odd combination. She was a damn good teacher, mind you.

This participant explicitly states that he would not have taken antidepressant medication, even if it had been recommended for him. In providing an account of this decision, he refers to a colleague, who did take medication while teaching. This combination of actions is criticised, through its description of being 'odd', as well as the participant's emphatic opposition to taking medication himself. Thus, medication is presented here as optional and not necessary. One implication of medication being thought of as unnecessary for depression is that depression becomes constructed not just a straightforward biomedical condition that can be simply treated medically.

Not all judgements about medication for depression were negative in our data. The participant in Extract 4 found it very difficult when his mother stopped taking her antidepressants.

Extract 4 (Interview 8)

P: Got a psychiatrist and they were going out to visit her on a regular basis once a week, and mum put an end to that. Got

medication for her and she stopped taking that [of her own accord].

I: Some of the medicine can make you...

P: Yeah but mum's one of the old-fashioned types that says 'I'm feeling alright now, I don't need these tablets and she's always stopping taking the medication she should be taking so it's a bloody headache sometimes. I have to check on the tablets she has been taking and make sure she's taking them at the right times.

Participants' discussions about others' use of medication for their depression showed ambivalence towards medication use. It is of note that when participants were discussing others taking medication for depression, it was typically women that they talked about. This may highlight the relative invisibility of men with depression (or at least men using medication to deal with depression). Participants' ambivalence towards medication use for depression reflected concerns about the impact of medications on lifestyle and family.

One concern about the impact of medication related to being unable engage socially – whether because medication would inhibit their ability to drink alcohol, or because of side effects such as mood swings. Although these concerns may be unfounded with the appropriate medication, they were nonetheless of note for participants, and suggest that individuals may form subjectivities of depression and treatments based on their understanding of others' experiences of depression.

Despite concerns about the side effects of medication, some participants worked to balance these against possible benefits. For example, the participant in Extract 5 was concerned he would suicide should he not take his medication.

Extract 5 (Interview 8)

I: Are you on antidepressants for that?

P: One tablet.

I: Does it help?

P: It makes me put on weight. Plus I'm not doing nothing and the weight's gone up a bit.

I: Do you find they help?

P: Yeah I was on a lot stronger ones before but at the start of the year I went to Malaysia with a friend of mine for 15 days. And I don't remember much of it. I really don't. And I love Malaysia because I was born over there and I've been back a few times. I usually have a ball over there but this time I just, very vaguely, remember things. I thought I was going to collapse over there, I felt cold shivers, not being able to concentrate on what I was doing, and I was walking around the hotel one day and I honestly thought I was going to faint. That's how bad it was. And that was scary not knowing what was going on but then they cut my tablets right back and I stopped taking antidepressant tablets there for a while. But I could feel myself sinking back again, thinking about suicide and all that sort of rubbish so I went back to the doctor and he put me back on the tablets.

This extract demonstrates a trade-off between several negative side-effects of taking medication (undesirable weight gain, for example), and the negative outcomes of not taking medication (such as feeling suicidal). This subtheme of talk about medication demonstrates a wide range of understandings of treatment for depression, including

ways in which men's subjectivities of depression treatment may be influenced by others' use of medication (such as in Extracts 3 and 4), and concerns about the impact medications may have on lifestyle (such as in Extract 5).

Gendered talk about seeking help for mental health concerns was common to many of the interviews. This aspect of participant's talk about depression was concerned with the barriers preventing men from seeking help, and how men position themselves while talking about seeking help in medical contexts.

Extract 6 (Interview 1)

I: So are there any issues...that you have wanted to talk to your doctor about but haven't been able to?

P: Many years ago, you wouldn't. The man, most men, males don't wanna bring anything up to their doctor. As you get a bit older, you get a bit wiser, you've been around for a while, you start to think hey you're stupid if you don't. Ask.

Extract 6 highlights how some participants were able to reframe their help-seeking as a masculine pursuit. Looking after one's health, and seeking help for health concerns have been considered to be 'socially feminised' activities (Courtenay, 2000; Johnson et al., 2012; Lyons, 2009). The participant may be orienting to this feminisation of health service access when he states that "males don't wanna bring anything up to their doctor". The participant was able to resist a stigmatised, feminised subject position by constructing help seeking as responsible and wise. In fact, he constructs failure to seek help as "stupid", emphasising the importance of seeking help. This extends the findings of previous research about how men might reject stigmatised subject positions (Galasiński, 2008). This extract highlights one way in which

masculinity may pose a challenge for men to seek help, but that masculinity may also provide a way in which men might reframe their help-seeking as wise and strong.

The theme of help-seeking was a dominant aspect of men's talk of depression. Participants oriented to medication and the stigma attached to help-seeking, which was partly reformulated by men who were able to retain masculine subject positions in their depression narratives. Talk about medication demonstrated ambivalent understandings, particularly in that medication may be seen as undesirable, but also potentially necessary.

Theme 3: Depression severity

Talk about the severity of depression was used to construct boundaries around what constitutes 'real' or 'clinical' depression. Some participants used discursive strategies to resist the construction of depression as a health problem. These strategies included choosing not to identify as a 'sufferer' of depression but rather as an individual unconcerned with their depression, or to reframe their depression not as wholly negative by reframing it as 'normal', 'unproblematic', or even as 'a blessing'. These constructions were often deployed in conversation in terms of comparisons. Talking about depression as merely feeling "down in the dumps", for instance, was contrasted with talk of depression as a mental health "crisis" (Interview 6). Furthermore, the diagnosis of depression was sometimes challenged, as in Extract 7. This participant emphasised that his depression may not reflect a pathological condition, but rather a 'natural' facet of his personality.

Extract 7 (Interview 6)

P: I think if I am stressed out I do get a bit depressed myself...I guess that's just the way I am. In fact I was seeing a mental health

professional briefly and they gave me...the diagnosis and said...
'you're suffering from depression' and it just made me laugh. I
thought 'I'm sorry this is just who I am. This is just the way I
am.' I didn't feel that there was anything terribly wrong with me
as such...It didn't seem very useful to have a label attached to my
head.

Extract 7 presents an example of how some participants positioned themselves as unconcerned with their depression. Such talk constructs depression as normal and unproblematic. Moreover, this participant had a clinical diagnosis of depression and severe depressive symptoms, but constructs his diagnosis of depression as unnecessary and unhelpful. Men's perceptions of depression severity are particularly relevant to whether they will engage in help-seeking – researchers have found that men will seek help for depression when they feel that their condition is 'serious' (Aromaa, Tolvanen, Tuulari, & Wahlbeck, 2011). This extract suggests that even some men with high depressive symptoms may deem their symptoms not serious enough to justify help seeking.

Another way in which narratives of depression provided alternative interpretations of symptoms and experiences was to emphasise the positive or constructive aspects arising from depression. For example, one participant found that because of his experiences with depression, he "can't afford to be stressed these days" and now focuses on the "better things in life" (Interview 3). Extract 8 provides another example and comes from a participant who referred to himself as 'blessed' to be able to experience a richer life through his depression.

Extract 8 (Interview 5)

P: I often say [that I'm] blessed. Because I've lived a much richer life than most people ever will.

I: That's a really nice way of thinking about it.

P: Yeah. Life is all about experiencing things – and most people don't experience things, they just walk straight through it.

Two key purposes are served by constructing depression as not entirely negative. First, rejecting the assumption that depression is only a negative experience may allow men to maintain masculine subject positions in their depression narratives. In the narrative of the participant in Extract 8, he did not position himself as a sufferer or a victim, but as living a blessed and full life. He notes that “most people” (those who do not have depression and therefore do not experience life to the fullest) “just walk straight through life”. With this statement, he constructs his depression as under control. Second, a focus on the positive aspects of depression could be a valuable coping strategy for men with depression. Recent policy developments have been based on the idea that men often adopt poor coping mechanisms in response to stress (Richardson & Carroll, 2008), thus better understandings of ways in which men emphasise positive aspects of experiences with distress are likely to be useful for researchers, practitioners, and policy makers.

This theme about depression severity demonstrates how some men choose to position themselves as ‘normal’ or ‘down’ individuals rather than men who were facing a health crisis. This highlights that assumptions about depression as wholly negative might be problematic. Further investigation into how men can reframe their experiences with depression in positive ways may be warranted based on these findings.

5.4.2 External factors

The second overarching topic of the interviews related to factors associated with depressive symptoms. This topic comprised two themes: (1) social factors; and (2) occupational factors

Theme 1: Social factors

Men's talk about the social contexts of their depression included discussion of social support and relationships, and social barriers to being communicative about their depression. The majority of participants discussed both positive and negative impacts of social support on depression. Close relationships were said to offer social support, but in some cases also presented opportunities for greater distress.

Discussion of social support focussed mostly on its several positive aspects. Some participants said that they would have suicided if they had not thought about the impact it would have on their family members and loved ones. Other participants reflected on the practical support that came from their close relationships – such as helping them to maintain treatment. Furthermore, social networks provided participants with a chance to share perspectives and to be exposed to new ideas and lifestyles. However, some participants talked about social relationships that encouraged rumination, thereby leading to poorer affect. Extract 9 is an example of one participant's views about his brother's mental health.

Extract 9 (Interview 3)

P: He's constantly surrounded by people with mental health issues. Which I don't think is very helpful in a way. I mean that's why I don't do anything, I'm not involved with any chronic fatigue organisations or anything like that. I mean, yeah, great if

you need the support, that's fine, but I don't want to be a part of that. I mean I don't dwell on it all the time or I don't focus on it a lot. Whereas my brother, his illness is his main focus in life.

In Extract 9, the participant constructs surrounding oneself with others with similar problems as a way of dwelling on the problem. He contrasts himself with his brother whom he perceives to have illness as his “main focus in life”. There appears to be a great deal of complexity involved in the production of subjectivities of illness in which social support is viewed as negative. Previous research on social support and depression has indicated that social support is protective against high depressive symptoms in certain contexts (Dew et al., 1997; Huurre, Eerola, Rahkonen, & Aro, 2007) but some studies suggest that social support does not always benefit everyone (Ahern & Hendryx, 2008; Coventry et al., 2009; Scholz, Crabb, & Wittert, 2013). Our findings in this section elaborate more on the relationship between social support and depression. Specifically, our interview data indicate that men do find social support to be beneficial in several ways, but that social support may be ineffective if it encourages rumination on sources or experiences of negative affect.

Participants also talked about barriers to being communicative about their depression. These barriers to communication were particularly evident when discussing embarrassment about depressive symptoms, as in Extract 10.

Extract 10 (Interview 8)

I: Well we've covered a lot of the questions

P: You haven't asked much

I: A lot of the answers have covered a few questions, which is great

P: It's just flowed. I'm not embarrassed. A lot of people are embarrassed if they've got depression and they don't wanna talk about it but it's the best form of release.

Embarrassment appears to be a barrier to discussing concerns of depression and seeking help and, ultimately, recovering from depression for some. It is noteworthy in this extract that the participant states that he is not embarrassed, but that "a lot of people are". If men understand or believe that a lot of men are embarrassed about being depressed, then this could impact upon their own feelings about depression. Previous research has considered how popular discourses of masculinity and depression can perpetuate stigma and being open about depression (Klin & Lemish, 2008; Nairn, 2007; Scholz, Crabb, & Wittert, 2014). Popular discourse reproduces the idea that men are embarrassed, thus more men may come to internalise such stereotypes, potentially creating a barrier to men being communicative about their depressive experiences.

Theme 2: Occupational factors

This theme focussed on the impact of role loss on depressive symptoms, and the workplace as a source of stress. In our interviews, participants were able to elaborate on issues associated with their role loss that they found particularly distressing.

Extract 11 (Interview 7)

P: Before my accident I was... fit as a mallee bull. Had my accident and that all went out the window and downhill and everything that was coming out the window... I really got in the dundrums and um yeah got pretty nasty there for a change.

Socially secluded. So we...rectified that problem, and found an

avenue out and since then I've spiralled from there and got out the hole... When I left the railways I was a supervisor. The day after my accident I was a nobody and it was devastating to me not to be able to do things straight away. And ah and that's what I need and that's what I miss so much. I missed all the guys that I used to work with because I went from outside living into here.

In Extract 11, the participant's narrative of his work accident reflects the complexity involved in such a situation. It included not only the loss of work role ("I was a nobody and it was devastating"), but also a loss of social connections ("I missed all the guys that I used to work with") and perhaps even a loss of sense of self ("before my accident I was...fit as a mallee bull"). Oliffe et al. (2013) have previously reported that men may experience a loss of engagement following retirement. Extract 11 provides an example of how the current study has extended these previous findings to situations that involve earlier, involuntary job loss. One implication of this finding could be that reengagement with the community may be useful for men experiencing depressive symptoms following such losses. Understanding the complexities of the role of occupational loss is important. A review of prospective cohort studies found that we do not sufficiently understand the relationships between role loss and men's depression (Scholz, Crabb, & Wittert, 2013) and thus these findings elaborate on the aspects of role loss that might impact on wellbeing.

Participants also discussed the impact of stress in the workplace. They talked about stress coming from time demands, lack of financial support, and a lack of appreciation in the workplace. These factors have been discussed in previous research about workplace stress (Niedhammer, Goldberg, Leclerc, Bugel, & David, 1998; Scholz, Crabb, & Wittert, 2013). Another compelling finding from our data was that

ruminating over workplace problems with colleagues was also potentially distressing (similar to the findings above regarding social support).

Extract 12 (Interview 6)

P: I think I used to talk about if I had problems when I was teaching the thing that used to help me the most was talking about the problems with people who were *not* teachers... So if I was feeling a bit stressed about teaching the last thing I wanted to do was talk to teachers... just for my personal mental detoxing it's not what I do.

Extract 12 provides an example of ways in which social support in the workplace might not always lead to positive outcomes for men's depression. The participant has used the term 'mental detoxing' which serves to position talking to colleagues about workplace problems as 'toxic'. Therefore, should workplace social support encourage rumination on sources of stress, it could in fact be problematic for some individuals.

The findings in this theme elaborate on existing literature which has found relationships between depression and both workplace stress and role loss (Niedhammer et al., 1998; Paterniti, Niedhammer, Lang, & Consoli, 2002). Specifically, our participants reported that relevant dimensions of role loss include financial issues, physical and social seclusion, and decreased sense of self-worth. Further, participants talked about workplace stress in terms of concerns regarding time demands. Ruminating over workplace problems with colleagues was also potentially distressing.

5.5 Conclusions

The findings of this study provide insights into how men express and deal with their distress, and the understanding they have of their symptoms of depression and the range of associated factors. First, we found that men drew on a biomedical discourse to explain depression (as in Extract 4, for instance, when biomedical treatment is constructed as necessary for depression), but situated their condition in the social context in which they live (such as in Extract 2 where not being able to work is discussed in relation to feelings of depression). These findings are similar to those of Lafrance (2007) who focussed on the way in which women negotiate biomedical discourses with the social contexts of their experiences of depression. Second, Galasiński (2008) identified discourses that men might engage in that maintain masculine identities when discussing their depression. Our findings elaborate on ways men might maintain masculine identities – through an emphasis on the positive aspects of their experience, or through rejecting the idea that help-seeking is not masculine. Third, our findings elaborate on men’s understandings of the external factors associated with their depression. Previous research has noted that there are many discrepancies in our current understandings of relationships between depression and a range of external factors (Scholz, Crabb & Wittert, 2013). The current study provides the perspectives of men’s accounts of several external factors related to depression to expand on current understandings.

We found that many participants made sense of depression by likening it to a physical health concern. In particular, men legitimised their distress through emphasising physical impairments, and talked about the links between physical health conditions and depression. Our interview data suggest that some men are concerned about balancing the risks and benefits of medication for depression. At the same time, men’s talk about depression emphasised the social contexts surrounding their

experiences. This finding has implications for practice, as it has been suggested that medical professionals' ability to diagnose and treat depression is hindered by the "dissonance between the medical and social model of depression" (Burroughs et al., 2006, p. 7). To improve interactions with patients, clinicians may benefit from a greater awareness and training in relation to the dual discourses of depression as both similar to a physical health concern, and as a condition experienced in social conditions.

Several men in our study highlighted positive aspects of their depression. Working positive experiences into their depression story appears to enable men to maintain masculine identities in their depression narratives. For example, by constructing themselves as not merely 'victims' of depression, men were able to speak about their experiences with a sense of agency. These men emphasised how depression had enabled them to focus on relationships, or how they perceived help-seeking as wise rather than emasculating. Such understandings of depression may have allowed men to better cope with their condition. Health service campaigns and providers may find value in encouraging men to find and focus on positive aspects of their experiences.

Particularly as previous research has suggested that cumulative losses and stresses throughout men's lives are a dominant feature of their depression narratives (Olliffe et al., 2011), it is pertinent to note that there are positive aspects to these narratives as well. It may be useful for future research to continue to explore relationships and activities in men's lives that encourage rumination, and work with men to find new perspectives and experiences of value.

There are several strengths of our research. First, although all participants had been assessed as having high depressive symptoms (as per the BDI), none of the men were primed to talk about their depressive experiences prior to our interviews. Men were asked only about health, stress, and coping in a broad sense. Thus the conversations about depression were driven by the participants, and men were able to

orient to depression when and in ways that were relevant to them. Similarly, because we did not use diagnosis of depression as a participation criterion, our results reflect the broader category of men with high depressive symptoms. Second, although all participants were recruited from one region, they included a broad range of ages, partnership status, and employment backgrounds, representing a diverse scope of experiences. Third, an advantage of thematic analysis is that it is well suited to a large and diverse data set. We were able to use thematic analysis as a way to organise and find themes across transcripts of lengthy interviews. Last, our research adds to the limited number of qualitative studies that have used data from men who have experienced high depressive symptoms themselves.

This research also has some limitations. First, there may have been a selection bias whereby the men who agreed to be interviewed may be different in their experiences of depression when compared with those who did not participate. Particularly, those who participated may have been those who were 'well enough' or who had already developed discourses about their health, stress and coping to help them deal with distress. Furthermore, the men had been part of the broader FAMAS study for ten years at the time of data collection, and their participation may have impacted upon their understandings of depression as a medical condition. It is possible that their participation in the FAMAS helped them to understand health in particular ways, allowing them to find words for their experiences of distress to which members of the general public may not have been exposed. Another potential limitation is that the interviewees may have responded in ways they felt were desirable. To minimise potential bias, we allowed participants to drive the extent to which rapport was built throughout the interview process and through the open-ended nature of interview questions.

Future research may explore how male patients and health professionals can communicate about mental health concerns to overcome stigma that may be attached to men talking about mental health concerns. This may be particularly useful given that participants most often talked about treatment in regards to women's depression rather than their own, and more work may be necessary to overcome barriers such as stigma and assumptions that men do not want to discuss such issues.

Chapter 6

Conclusion

6.1 Chapter Outline

This chapter provides a discussion of the overall research project and explains the challenges and benefits of conducting the research for this dissertation. I then explore the implications of this research for our understandings of how men's depression is perceived and experienced in Australia. The relevancy and need for critical research – in terms of aims, methodologies, and formulation – will also be discussed. Last, I suggest how future research that engages with ways to challenge stigma and stereotypes is necessary for promoting positive outcomes for depressed men.

6.2 Review of Findings and Contributions

One of the major threads throughout the individual studies presented in this dissertation is a tension between competing understandings of men's depression. This tension relates to ways in which biomedical understandings of depression in men, while still very dominant, do not account for the entirety of men's experiences with the condition. In this section, I will discuss key findings from each of the studies, and also provide an explanation of how this tension between the biomedical model and the social contexts of depression is present in each chapter. Within this section I will also discuss the contribution made by each study presented.

From each study within this dissertation, it can be seen that men's depression may be understood in a number of ways across different contexts. Two of the aims of this research, as discussed in Section 1.4, are to build better understandings of personal, psychological, and social contexts of depression, and to contribute to the growing body of literature focusing on men's depression. These aims were met by conducting diverse

studies united by the theme of men's depression. This dissertation contributes to the field by 1) providing a narrative synthesis of current research findings about factors related specifically to men's depression in the systematic review in Chapter 3, 2) extending research on discourses of men's depression to the ways in which public messages might work to construct or deconstruct stigma in the media analysis in Chapter 4, and 3) exploring the insights of men who have experienced depression in the interview study in Chapter 5, thus providing more context to current biomedical-centred understandings of men's depression.

In Chapter 3, I provided a systematic review of published prospective cohort studies which focus on incidence or change in depressive symptoms in adult men (Scholz, Crabb, & Wittert, 2013). Two of the main contributions to literature made by the systematic review are that it provides an outline of predictors and outcomes of men's depressive symptoms over time, and that it considers multiple predictors including social and demographic factors, occupational factors, occupational factors, health behaviour factors, and psychological and cognitive factors. Another contribution of the systematic review is that it extends previous understandings of men's depression by systematically collating the findings of prospective cohort studies in one review.

Specific social and demographic factors that were found to be associated with greater incidence or worsening of men's depressive symptoms included not being married (or having marital dissatisfaction, having low family education, having low social contact, having a low employment grade, having parents who had experienced depression, or being a caregiver. Specific health behaviour factors that were associated with greater incidence or worsening of men's depressive symptoms included having an alcohol dependence (or excessive alcohol intake), smoking, and not engaging in physical activity. Specific disease status and risk factors found to be associated with greater incidence or worsening of men's depressive symptoms included having poor

health in general, being HIV-positive, having clinically defined insomnia, having had a myocardial infarction, experiencing pain, or having low physical ability. Last, specific psychological or cognitive factors associated with a greater incidence or worsening of men's depressive symptoms included having been depressed previously, having anxiety, suicidal thoughts, hopelessness, and stress.

Factors that were not found to be related to a greater incidence or worsening of men's depressive symptoms included being a parent, the size of the household, whether men lived in rural or urban settings, age, personal education level, moderate alcohol intake, experimentation with sex, self-rated amount of sleep and sleep quality, having diabetes, cancer, and engaging in antisocial behaviour.

The findings of the review revealed inconclusive understandings about several relationships between some factors and depressive symptom development. For example, findings regarding the impact of income on depressive symptoms were not conclusive regardless of whether studies focussed on household income, personal income, or parental income. The disparate findings in regards to these factors highlighted areas that may need further research.

Importantly, the systematic review of the literature highlighted that the body of research dealing with men's depression has found a number of factors related to depression. However, one of the implications of these findings for my research is that there are also many discrepancies and relationships that biomedical theories of depression have yet to account for, highlighting the first site of tension in the primacy of the biomedical model. For instance, it is not clear how a biomedical model of depression would account for all of the factors found to be associated with depressive symptoms within the review (such as having marital dissatisfaction, or lower levels of education in one's family). Indeed, given the wide range of factors found to be related to incidence of or change in depressive symptoms, and the discrepancies found for

many factors, the systematic review could support both models of depression that suggest that multiple stressors lead to depressive outcomes (Gilbert, 2006), and models of depression that suggest pathoplastic relationships between particular factors and depressive outcomes in men (Widiger, 2011). It is important in light of these discrepancies to build a greater understanding of the social contexts in which men's depression is experienced.

Building a greater understanding of the social contexts in which men experience their depression was one of my motivations in Chapters 4 and 5. In Chapter 4, I used news media articles to examine portrayals of men's communication about their depression (Scholz, Crabb, & Wittert, 2014). One of the main contributions of the analysis of news media articles was that it added to the understandings of ways in which stigma about men's depression is reproduced. As such, it extends the findings of Stuart (2006) by providing specific instances of ways in which the media may have some responsibility for negative images of mental health. Another contribution of Chapter 4 was that it extended on the work of Johnson et al. (2012) by providing examples of ways in which media might present stories that emphasise positive actions available to men experiencing depression.

My analysis in Chapter 4 suggested that news media articles about depression may increase understandings of depression and therefore reduce stigma about men with depression, but that only having popular or successful men portrayed as being depressed may emphasise the differences between most men and men who have depression. I also raised a concern with news media articles constructing depressed men as having sole responsibility for rejecting stigma and being communicative about their depression. Such a construction could be problematic as it does not encourage a shift in the social stigma itself. Furthermore, some articles perpetuated gendered norms of health

management – emphasising women’s roles in men’s health outcomes and at the same time reproducing the stereotype that men will not engage in their own healthcare.

From my analysis, I posited that it is problematic when responsibility for being communicative is placed solely on the depressed individual, or on the depressed individual’s (usually assumed to be female) significant other. This analysis built on previous research such as that by Seymour-Smith and colleagues (2002) who discussed how health professionals reproduce normative discourses about expectations that women should be responsible for men’s health. Chapter 4 extended such findings to news media contexts, with a discussion of ways in which similar expectations of woman are present too in news media, and that public dissemination of such discourses may have implications for the ways in which men believe they should act when experiencing mental illness. In a literature review of men’s help-seeking behaviour, Galdas, Cheater, and Marshall (2005) discuss findings across several studies that suggest that men might internalise gendered norms. Through this process, men may feel they need to be silent about their problems so as not to feel weak or foolish. Therefore, I argue that encouraging change at a social level in order to reduce stigma around men openly expressing their depression would place less responsibility upon the depressed individual (or their significant others) and might lead to men engaging more easily in mental health help-seeking.

This media study also highlights the tension between the biomedical model and the social experience of depression that I identified earlier in relation to the systematic review. In Chapter 4, stigma is highlighted as being a factor that can be reproduced by media portrayals of men’s depression. The study extends Vahabzadeh and colleagues’ (2011) work into media’s role in stigma reproduction to the specific context of men’s mental health. Importantly, stigma also has implications for the help-seeking capacity of men. Thus this study emphasises that despite the possibly biomedical nature of

depression, there are socially constructed and situated aspects of depression such as stigma which need further understanding and attention.

In Chapter 5, I examined depressed men's subjectivities about depression. I discussed two overarching topics within the interview data. The first of these was concerned with how men talked about depression in relation to health. The second was related to external factors associated with depression and included social contexts, and occupational contexts. There were three key contributions made by Chapter 5. First, it extended the findings of the systematic review in Chapter 3 by expanding on ways in which some men understand certain predictors of depressive symptoms. Second, it extended the research of Lafrance (2007) to men. Lafrance (2007) discusses ways in which women negotiate biomedical discourses with the social contexts of depression. Chapter 5 suggests that men too have trouble negotiating these competing understandings of depression. Last, another contribution made by Chapter 5 is that provides examples of ways in which men might maintain masculine identities when experiencing mental health concerns (for example through emphasising positive aspects of the experience). This extends the work of Galasiński (2002), who called for further work to explore ways in which men discursively construct themselves as masculine in such circumstances.

The analysis of the interview data focused on the meanings and the practical and theoretical implications of each theme. Several issues were important to men in their experience of depression. The tension between the biomedical model and the social contexts of depression arose again in Chapter 5. Men often talked about depression in relation to biomedical disease, but also drew on social contexts to explain their illness experiences. In other words, although some men discussed biological aspects of depression, a number of factors such as social support, employment, and family were also important parts of their discourses of depression. This highlights the complexities

that depressed men have to negotiate in relation to the condition. These findings enriched current understandings of men's subjectivities of depression in terms of health and external factors. Given that there have been calls for better understandings of men's accounts of their distress (Addis, 2008; Ridge, Emslie, & White, 2011), Chapter 5 has provided some necessary insights into a broad range of men's accounts of depression.

The tension between the primacy of biomedical understandings of depression, and the social context in which depression is experienced unifies the overall research project, with particular implications for research in the future, which I will discuss further in section 6.4.1 in this chapter. Previous research has found that women with depression privilege biomedical understandings of depression over the social contexts of their experience (Schreiber & Hartrick, 2002). This dissertation demonstrates some of the concerns of the primacy of biomedical understandings of depression over the social contexts of depression within men's talk about their depression, media portrayals of their depression, and the scientific literature about depression in men.

There is much diversity between the studies of this research project in terms of data source, and analytic methods. However, an important common theme throughout all of the streams of this research is that understandings of depression that are rooted purely in biomedicine do not fully capture men's experiences of depression. In Chapter 1, I discussed some of the valuable research that has critiqued the way that biomedical understandings of depression do not capture the nuanced experiences of women's depression (such as that by Lafrance, 2006; 2007). The findings of the research studies in this dissertation, taken together, extend these findings to men's experiences of depression as well. The systematic review presented in Chapter 3 presented a broad range of factors associated with the incidence of or change in depressive symptoms. A number of these factors were psychosocial – such as workplace stress, or social connectedness. It became evident through the review of broad factors related to

depressive symptoms that biomedicine alone was not enough to capture the entire nature of depression. This is because particular biological circumstances were not antecedents of depression in most men. Thus it appears that for many of the factors discussed, either a diathesis-stress model (in which particular stressors interact with a vulnerability for depression) (Haefffel & Hames, 2013), or a pathoplastic model (in which factors are related to depression in non-aetiological ways) (Klein, Kupfer, & Shea, 1993) might explain the links between various factors and depressive symptoms.

Stigma was another recurring factor associated with men's experiences of depression in one way or another in both Chapters 4 and 5. In Chapter 4, the psychosocial factor of stigma was constructed as a potential barrier between men and their seeking help for depression. In Chapter 5, men oriented to stigmatised aspects of depression within their interviews. For example, some interviews referenced the stigma associated with taking medication for mental illness. As stigma is a social aspect of men's experiences of depression, my findings emphasise that drawing on biomedical models of depression alone is not sufficient to improve men's experience of the condition. A more holistic understanding is necessary to explore ways in which stigma is reproduced and the implications stigma has on men with depression.

6.3 Strengths and Limitations

In this section I will initially discuss some strengths and limitations of the research project as a whole. Then I will discuss strengths and limitations of each study in the context of the broader research project.

The first overall strength of this dissertation is that I have used a range of methodologies to triangulate understandings of depression in men. Thus, methodological problems associated with each study are mitigated by other studies in the dissertation. For instance, the systematic review incorporates much quantitative

work based on survey questionnaires; hence the findings are subject to some of the same limitations as questionnaires. These limitations include social desirability bias, forcing individuals into particular categories, and not capturing individuals' circumstances (Galasiński, 2008). Importantly, studies included in the review may have imposed categories of depression (I only included studies that had used standardised measures or inventories of depression), which may not reflect the experience of depression. Such limitations are countered by the benefit of qualitative research which allows researchers access to participants' own thoughts. Specifically, in my interviews with participants, they were able to create their own categories of depression through talk (the men in my interviews were asked about stress but not depression, thus giving them the opportunity to talk about depression only if and in ways in which it was important to them).

In addition, I have used a broad collection of data sources to inform this work. Specifically, I have reviewed published prospective cohort studies that focus on change in depressive symptoms in men, analysed how the media might work to reproduce or challenge stigma around men's depression, and explored the major themes arising from men's talk about their subjectivities of depression.

Last, the findings of each of these studies have implications for health policies and practice. They are directly relevant to campaigns currently under development such as those by Spur Projects (2012) which seek to change stigma and social constructions of masculinity to promote better mental health outcomes for men. Further, the research addresses a priority of the Australian Research Council: the promotion and maintenance of good health. Specifically, I have contributed to the individual research goals of 1) minimising social and environmental factors associated with poor health, 2) improving mental capacity through the development of social, medical and population health strategies, 3) encouraging the adoption of healthier lifestyles, and 4) advancing the

understanding of Australia's social structure in the interests of greater health, productivity, and individual fulfilment (Department of Industry, Innovation, Science, Research and Tertiary Education, 2012). Currently, there are several new men's health policies which are calling for a strong evidence base on male health (for examples see Australian Institute of Health and Welfare, 2011; Richardson & Carroll, 2008) and my research adds to the developing body of evidence in the field.

There are also some limitations to the research in this dissertation. First, my media analysis and my interview study focused only on Australian contexts. Issues about hierarchies of masculinities, and the feminisation of healthcare are not limited to Australia (Connell & Messerschmidt, 2005). Indeed, Australia shares many cultural and socioeconomic features with other countries, including New Zealand, United Kingdom and Canada. Thus, I would suggest that my findings remain relevant outside of Australia, although further research would be required to confirm this.

6.3.1 Systematic review

From my perspective at the beginning of this project, the systematic review was conceived of in order to provide a knowledge base for my thesis. To do this, it needed to provide a broad overview of factors associated with men's depression, and report on the various streams of research that are relevant to depression in men.

A limitation of the systematic review in was that it only enabled me to report on certain research. For example, some studies such as qualitative studies and cross-sectional studies did not meet the inclusion criteria for the review. A consequence of this is that the richness and depth present in some of these studies was not able to be included in my review. Further, although it was important to have definite inclusion criteria in order to satisfy the systematic nature of the review, this forced me to exclude studies that did not meet the criteria but which were relevant to the theoretical

background and the research content of my overall project. This included studies on women, younger males, and clinical studies (many of which have been discussed in Chapters 1 and 2 of this dissertation). In future research, I would consider using systematic review approaches that allow for qualitative research to be included (Verbeek et al., 2012). Such approaches still allow a systematic, and therefore reliable, synthesis of the data, but also benefit from the greater flexibility of including a broader range of research into the review.

Another limitation of the systematic review approach is that the results are constrained by the details that are presented in the publications included in the review. Where authors had not published adequate details about their research, their papers may have been excluded from the review. For example, when assessing studies for potential inclusion into the review, I noted that some did not report whether participants were older than 18 at follow-up, whether depressive symptoms were measured at baseline or follow-up or both, or how depressive symptoms were assessed. Such studies could not be included in the review. This limitation, again, is part of the design of the systematic review. By definition, systematic reviews are systematic and adhere to strict criteria of exclusion and inclusion. Thus although my review was limited by not being able to include all potentially relevant studies, it benefitted from being able to present an overview of the best evidence available.

A strength of the narrative approach to systematic review used in Chapter 3 is that it did not seek to statistically meta-analyse the included data. Therefore, even where studies did not include adequate detail about covariate variables, they were still able to be included in the overall narrative synthesis.

Another strength of the systematic review in relation to the broader research project was that it did achieve its aim of providing a broad, evidence-based background to my research program. It allowed me the opportunity to read widely and deeply into

relevant literature. It included studies of an appropriate nature; observational cohort studies allowed for naturalistic data about factors associated with men's depression to be examined.

A 'real world' strength of using the systematic review approach to build a broad literature base for the subsequent studies of my dissertation was that such an approach provides an effective and practicable way of assessing relationships between various factors and depressive symptom outcomes. While it would be useful to build a large-scale, observational, longitudinal cohort study to focus specifically on the development of depressive symptoms in men, such research would be constrained by funding, availability of participants, and logistical limitations that would be impossible to work around during a doctoral dissertation. Therefore, conducting a systematic review on previously published articles about depressive symptoms in men provides a feasible method of doing research within the constraints of a doctoral project.

6.3.2 Media study

The media analysis aimed to explore portrayals of depression in men and the discourses that they reproduce. To this end, it employed a discursive analytic approach to look at how men were portrayed as communicative (or not communicative) about their experiences with depression. Here I will discuss both limitations and strengths of this study.

The first limitation of my media analysis is that I focused on only one type of media (news articles) published in one country (Australia). A focus on broader forms of media (such as television programs, music, magazines, or social media) may reveal further insights into how men with depression are portrayed. Stories within television dramas about men's depression may challenge or reproduce norms of masculinity and mental health in novel ways. They may have implications for providing men with

alternative discourses for their experiences with depression, for instance, and would therefore be theoretically relevant. The rise of social media as a means for transmitting health information may also have implications for the ways in which people make sense of men's communication about depression. Thus future research may consider whether other forms of media play similar roles in challenging or reproducing stigma.

Additionally, a focus on discourses of men's depression in news media in a broader range of countries may also yield further insights into portrayals of men's depression. Even though New Zealand is culturally similar to Australia (Brewer, 2007), there have been some significant developments in the visibility of men's depression in New Zealand. This follows John Kirwan's (2010) 'coming out' story of depression. Kirwan is a well-respected, world-famous rugby player from New Zealand whose story of depression impacted upon how men's depression has been portrayed in New Zealand media. A focus on the differences between Australian and New Zealand portrayals of men's depression since Kirwan's book was released may reveal differences in discourses of depression. Given that Kirwan is still seen as a typically masculine man in New Zealand, there may be discursive differences in how he and other depressed men have come to be portrayed. Such discursive differences may be productive in opening up new discourses and perspectives for men to talk about or understand mental health concerns.

A second limitation of the media analysis is that discursive analysis has been criticised for providing only a possible interpretation of the data (Morgan, 2010). Engaging in this kind of research required me to be explicit about my conclusions being merely possible conclusions. During the process of preparing this dissertation, it became clear that this limitation was not only a concern of qualitative research. Rather, scientific research of any kind provides one interpretation of data. This interpretation must be supported by the data. Even if the conclusions drawn in Chapter 4 are

questioned, they are still supported by the data, and I have discussed them in relation to existing theoretical understandings of gendered health portrayals. It would also be the case for a quantitative analysis of data that the interpretations of the findings need to be discussed in relation to existing theory.

One of the strengths of focusing on news media portrayals of men's depression is that news media is relatively widely distributed. The articles that were present in my searches included pieces that were available online, in print form, and in a range of urban, regional, and rural areas. Therefore the discourses of communication that I focused on for analysis were published in highly circulated news media with high readership rates across Australia in both print and electronic forms. Thus such discourses reflect ways of understanding men's depression that are being read across the country in a wide range of settings.

Another strength of Chapter 4 to mention here is that the production and dissemination of news media is undoubtedly driven by the saleability of particular news stories. Editors need to make a number of decisions about what kind of news 'fits' their publication and what is going to be newsworthy (Lewis, Kaufhold, & Lasorsa, 2010). Thus stories that portray celebrities or suicide or mental 'illnesses' in certain ways might be more likely to be published within newspapers. Indeed, several media articles in the data corpus (and some of the data extracts included in Chapter 4) make connections between men's depression and suicide. Public messages linking depression to suicide may also reproduce certain stigmatised ideas about what it means to have depression. It is noted within the chapter that these media articles produce and are produced by discourses that are present within society more broadly. Thus readers might internalise the stigma or other messages that are reproduced in these articles regardless of whether or not they are about celebrities or other 'successful' individuals.

In discussing my methodological approach in Chapter 2, I noted that an anticipated benefit of analysing media data was that it was naturalistic. Having completed my study on media portrayals of depression in men I still suggest that the naturalistic data has been beneficial to this overall research project. This is because it has allowed me to explore data that the public encounter through their interactions with news media. These news articles about depression may be forming people's ideas about masculinity and depression in an organic way. The news media articles were produced by the media, and consumed by readers. Further, as the stories are relatively widely distributed, the portrayals within them produce (and are produced by) subjectivities of men's depression.

6.3.3 Interview study

The final analytic chapter in this thesis presents a thematic analysis of interviews that I collected with men who had experienced high levels of depressive symptoms. Several questions within the interview schedule (Appendix B) were based on the systematic review and the media study that form the first two studies of this dissertation.

First, the systematic review found that many varied factors were related to depression. Therefore, some interview questions were designed to elicit participants' thoughts about broad biological, psychological, and social factors potentially related to their depression story. Such questions included "so far we've focused on physical health – is there any other kind of issue related to health that are important to you?" which was used as a prompt question for participants who had only mentioned particular experiences. Another such question was "when was the last time you felt you had some emotional difficulty?" and the follow-up question "what helped you through this time?"

These questions were designed to encourage participants to elicit whether particular social factors hindered or helped their mental distress.

Second, the media analysis found that news articles portray communication as a step towards recovery. This was incorporated into the interview questions by asking participants, for instance, “do you ever talk to a doctor or other health professional about emotional difficulties?” and “have [doctors] ever asked [about emotional difficulties]?” The media analysis also found that there are still problematic gender portrayals in articles about men’s depression that may reproduce the idea that individual women should be responsible for men’s depression. To explore these ideas further, I asked participants about how females in their life (partners or others) might deal with such issues.

The aim of the interview study was to examine the breadth of men’s subjectivities of depression. In order to report adequately on this breadth, I conducted a thematic analysis of the entire interview data set.

The first issue of note is that participants were drawn from a larger, longitudinal cohort study – the Florey Adelaide Male Aging Study (FAMAS). This was both beneficial and limiting. A limitation of drawing participants from the FAMAS is that they may have developed particular language, understandings and subjectivities of their health by virtue of participating in the broader study for more than 10 years. The advantage of these men participating in my research interviews was that I already had data on their depressive symptoms. I knew that all participants had experienced depressive symptoms. As such, I was able to ask men about their experiences with health, stress, and coping without needing to ask them specifically if they had been depressed. This produced interview data whereby men talked about depression only where relevant or important to them, rather than talking about depression because I (as an interviewer) had to ask them. Another limitation of this interview study is that data

were collected at a single time point. This is particularly important as my media analysis suggested that there might be an increase in public awareness and portrayals of men's depression with time. As this change in awareness may begin to impact upon men's subjectivities of depression over the upcoming years, future research might consider looking at changes in these subjectivities over time.

Prior to conducting the research interviews – as discussed in Chapter 2 – I was concerned that men would not want to talk about sensitive issues to do with their mental health. Additionally, I was concerned that my younger age and my never having been depressed would be a barrier to the interview process with my participants. I had set out to build rapport with participants, developed an interview schedule that did not assume that depression was a problem for participants, and held the interviews in the participants' houses or workplaces in order to make them feel comfortable with me as in interviewer. This strategy worked well in that I collected more data than initially anticipated. I had thought that each interview would take approximately 30 minutes, but several of the interviews with participants lasted a longer time than expected. It seemed that men in fact do have a lot to say about their experiences with mental health, despite common assumptions to the contrary.

An advantage of the thematic approach for the study in Chapter 5 is that it enabled me to organise, summarise, and analyse a very large data set. A thematic approach provided me with the analytic tools to seek out themes within the data, and the ability to explore links and relationships between themes.

Furthermore, the thematic analytic approach was particularly appropriate to investigate men's subjectivities of depression. Given that understanding in the area of men's subjectivities of depression is still developing, it is important at this stage to build up a broad knowledge base. The thematic analytic approach is flexible and can be used to focus on one specific theme, or to provide a broader overview of all the themes in a

data set (Braun & Clarke, 2006). I chose to use the approach to provide an overview, and there is now some more understanding of a wide range of themes of men's subjectivities of depression to potentially explore further. It should be noted here that there may be limitations to having chosen to focus on the wide range of themes. For example, an analysis focusing on just one aspect of the data but in more depth could be useful to continue to build understandings of men's subjectivities of depression. The aim of this exploratory study in the area was to look at the range of themes present in men's talk about their experiences with depression, but future research might focus on specific aspects of men's talk and explore those more fully.

6.4 Implications

There are several implications of my research that I would like to highlight in this concluding section of my dissertation. These include potential implications for research, for practice, and for policy.

6.4.1 Implications for research

The first implication of this dissertation for future research in the field is that it may be beneficial for more studies to explore men's depression without imposing upon participants predetermined ideas about what constitutes mental health and illness. As previously stated, there was a theme across the findings in this dissertation that there may be a tension between the primacy of the biomedical model and the inability of that model to account for broader contexts of depressive experiences. Research that continues to explore these contexts will contribute further and improved understandings of men's depression. Participants in my interview study (Chapter 5) were responsive and engaged, despite common assumptions that men would not discuss their issues as elaborated in Section 2.3.3. The interview schedule did not assume that men were

depressed, nor did it assume that depression was necessarily important or relevant to, or problematic for, these men. Rather, it focused on men's broader experiences with health, stress and coping, and men were able to orient to depression when and in ways that were relevant to them. Allowing participants to discuss health issues relevant to them provided a rich qualitative data source. As this has been beneficial to my research, I would consider ways in which I can conduct research in the future with an aim to avoid reproducing researcher bias in regards to phenomena being studied.

The interview study I present in Chapter 5 of this dissertation offers an overview of men's subjectivities of depression that is intentionally broad. In future research, I would recommend consideration of more in-depth analyses of specific aspects of these broad subjectivities. For example, a more detailed analysis of men's talk about the role of social support in their subjectivities of depression may lead to greater understanding of the ways in which men may engage with social support and achieve greater health outcomes.

Furthermore, future research could focus on multiple stigmatised positions and their relationship to depression. Masculinity is not the only context in which men experience health and illness. A detailed analysis of socio-economic status and masculinity, or racial background and masculinity, or remoteness and masculinity (or any combination of the above or other potentially relevant factors) is necessary to understand the role of intersectionality in men's experiences with depression. Indeed, as shown in Chapter 3 of this dissertation, a diverse range of factors is relevant to men's experiences with depression, highlighting the complexity of depression in men.

Several of the concerns I had about the research presented in this thesis in regards to the juxtaposition of the dominance of the biomedical model with the psychosocial aspects of illness are concerns of the area of health psychology more broadly. Other researchers have discussed issues in our current understandings of

linkages between biological, psychological, and socio-cultural aspects of health (Suls & Rothman, 2004). Health psychology has been criticised for its focus on psychosocial aspects of health and ignoring physical aspects, while medical research has been criticised for ignoring the psychosocial while focusing on the physical (Ghane & Sweeny, 2013). I have attempted to bridge physical and psychosocial aspects of health in the interview study presented in Chapter 5. I highlight here Ghane and Sweeny's (2013) argument that shifting the focus of health psychology research to the interfaces between the physical and psychosocial experience of illness may make contributions to the field. My dissertation adds to the body of such critical research by emphasising that a single understanding of depression may not capture the multiple contexts of men's depression.

6.4.2 Implications for practice and policy

The findings of this research project also have implications for public health and clinical practice. First, based on my findings around the relevance of the social contexts of men's depression, it may be useful for future health campaigns to focus on such contexts. Indeed, despite a large body of stigma reduction research, major Australian research and program grants are still focusing on what can be done to reduce stigma associated with depression among men (beyondblue, 2014). Thus, my research contributes to this knowledge and highlights the role of the public sphere in being able to challenge or reproduce stigma (Chapter 4). Reducing the stigma experienced by men may encourage more individuals to use health services. If men with depression are made solely responsible for defying stigma and seeking help (as was the case in news media portrayals of men's depression in Chapter 4) then more can be done to remove that stigma on a social level.

Indeed, my research has already been used to inform a national health campaign in Australia. Spur Projects has drawn on ideas from my research program to inform their ‘Soften The Fck Up’ campaign that has been running in Australia (Spur Projects, 2012). The campaign aims to take the focus off of individual men with depression, who are often told to ‘harden up’ or ‘suck it up’ when they open up about their concerns. Informed by my media study (in Chapter 4), the campaign shifts the focus on depression onto the social stigma of depression and distress in general. It aims to raise awareness about the need for people to be open to communicating with each other, instead of treating help-seeking as something that is solely the responsibility of the depressed man. Soften The Fck Up aims to adapt the dominant constructions of masculinity in society, such that it is easier for men to discuss issues around their distress than it is for others to tell them that they need to ‘harden up’. When planning the campaign, Spur Projects consulted with me about the language that should be used to emphasise that the reduction of depression stigma is not the responsibility of individual men, but of everyone. The campaign therefore aimed to ensure that neither biomedical explanations of depression (informed by the study in Chapter 3), nor stigmatising language (informed by the study in Chapter 4) were central to the message. In this way, the current research has already had clear applied benefits. Campaigns such as the Soften The Fck Up campaign need to be evaluated to fully explore how people are engaging with them, and whether they might provide a useful intervention.

Campaigns that challenge these constructions of masculinity may be particularly timely given recent health messages in Australia that have reproduced dominant norms of masculinity. For example, the Man Therapy campaign (beyondblue, 2013) appears to use caricatures of masculinity to deliver its men’s health messages. Further research may need to explore the extent to which such messages are effective at challenging stigmatised versions of men’s health (while resisting stigmatised or problematic

positionings of men and masculinity). If they reproduce stigma against help-seeking then they might, in fact, be doing harm to the men's health movement.

Second, health policies aimed specifically at men's health are still relatively new. One national health policy that has focused on the social construction of masculinity and its role in health care and health outcomes is Ireland's National Men's Health Policy (Richardson & Carroll, 2008). This policy emphasises the need for health care to be aware of and responsive to aspects of masculinity at all life stages – it aims to increase awareness of healthy masculinities in young boys, and on the other end of the spectrum aims to be reflexive to the needs of men in retirement. Such a policy is relevant to men's health because it does not aim to change men, but rather to change healthcare to be more engaged with men's needs. My experience with the interview study in Chapter 5 suggests that men will talk about their issues with depression. This supports the work of O'Brien, Hunt, and Hart (2005) which emphasises the lack of empirical evidence behind the assumption that men will not talk about their problems. While the study in Chapter 5 was conducted with only a small sample of men, participants in this study had a lot to say about their subjectivities of depression.

In fact, although ignoring or denying depression is suggested to be one way that masculinity is enacted (Schofield et al., 2010), it may have also been that sharing stories or advice about their life experiences with me was another way in which participants in the interview study enacted masculinity. Thus policies that respond to men's needs and provide innovative places and spaces for them to seek help or share experiences in appropriate ways may lead to greater mental health outcomes for men.

Last, the tension between the biomedical model and the broader social context of men's depression has some implications for health services. In discussing their experiences, I found that men drew on biomedical explanations of their illness, but also incorporated social contexts into their depression narratives. These narratives

reproduced assumptions of biomedicine, which blame the patient in cases where health care practices fail to provide positive health outcomes (LaFrance, 2007). If health service providers can begin to engage in more nuanced discourses that account for social contexts of men's depression, and avoid using language that blames individual patients, then this may have benefits for engaging and retaining men in health services.

Gender in practice

Throughout this dissertation, I did not aim to compare depression in men with depression in women. I focused only on men's depression. It was not within the scope nor the aims of this dissertation to discuss whether or not men and women are different in terms of how they experience depression, how they express depression, and how they seek help for depression. Rather, it was my aim to explore and expand upon knowledge of depression in men.

It is with such a position in mind that I also argue for campaigns or services (such as Soften The Fck Up mentioned above) to focus specifically on men's issues. While I do not assume that men and women experience depression differently, respond to it differently, or have different subjectivities of depression, I note that many of the men who participated in my research still had several gendered ways of making sense of mental health help-seeking. When talking about their issues with mental health, 'being a man' was a common idea to which many participants oriented. For example, one participant stated that "the man, most men, males don't wanna bring anything up to their doctor" (Chapter 5). Therefore, even if there are no differences in men and women's experiences with depression, gender is still a factor that appears to be important to men, and forms part of their subjectivities of depression. Thus I would argue that it is important that campaigns and services cater for gender-specific

operations if they are to continue to encourage men to seek help for their mental health concerns.

6.5 Concluding remarks

In this chapter, I aimed to reflect on the range of concerns, challenges, and positive aspects of the overall research project. I found that one of the most difficult parts of doing research on men in depression, was that I felt that I would risk reproducing dominant understandings of ‘depression’ as a clinical illness and of ‘men’ as ‘bad’ at health. It was not my intention to do so, nor was it my intention to deny understandings of depression as a clinical illness or to argue that the men perform any better or worse at health than others. My aim was to research depression in the contexts in which it is understood by others.

The category of ‘depression’ is commonly understood in social encounters (as captured through the interview study in Chapter 5), and understandings of depression are both informed by and inform media constructions of the condition (as in the media study Chapter 4). In turn, these constructions of depression are shaped by, and themselves shape, scientific understandings and constructions of the condition (as in the systematic review in Chapter 3).

The research presented in this dissertation found a tension between the biomedical model of depression and the broader social contexts of men’s depression. This tension was present in a) scientific literature in which biomedical knowledge was found to not yet account for discrepancies in understandings of men’s depression, b) news media articles in which the social factor of stigma was reproduced – potentially impacting upon men’s ability to seek help and ‘recover’ from depression, and c) men’s own discourses of depression in which the condition was dominantly expressed in terms of the social contexts in which it is experienced. This is not to say that the biomedical

model is 'wrong', but rather emphasises that the divide between the dominant biomedical model and the social context of men's depression may have implications for researchers, media producers and consumers, and men's subjectivities of depression.

The findings of this research have contributed to the growing body of research on men and depression. It is my hope that these findings will be used to inform mental health service provision, public health campaigns, health practitioners and further research. Such work might improve outcomes for men experiencing depression through better understandings of men's subjectivities of their depression, greater mental health literacy, and increased public engagement with mental health discussions.

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Appendix A: Research Ethics Committee Approval



Government of South Australia
SA Health

15 November 2010

Mr Brett Scholz
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Research Ethics Committee

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Dear Mr Scholz,

**Re: "Understanding the experience of depression in men: A qualitative enquiry."
RAH PROTOCOL NO: 101109.**

I am pleased to advise that Research Ethics Committee EXPEDITED APPROVAL is granted to the above project on the above date. The following have been reviewed and approved:

- Protocol, Version 2, November 2010
- Participant Information Sheet and Consent Form, Version 2, November 2010
- Questionnaire: Health, stress and coping, Version 1, October 2010
- Letter of Invitation

Please quote the RAH Protocol Number allocated to your study on all future correspondence. Research Ethics Committee deliberations are guided by the NHMRC National Statement on Ethical Conduct in Human Research 2007.

GENERAL TERMS AND CONDITIONS OF ETHICAL APPROVAL:

- Adequate record-keeping is important. If the project involves signed consent, you should retain the completed consent forms which relate to this project and a list of all those participating in the project, to enable contact with them in the future if necessary. The duration of record retention for all clinical research data is 15 years.
- You must notify the Research Ethics Committee of any events which might warrant review of the approval or which warrant new information being presented to research participants, including:
 - (a) serious or unexpected adverse events which warrant protocol change or notification to research participants,
 - (b) changes to the protocol,
 - (c) premature termination of the study,
 - (d) a study completion report within 3 months of the project completion.
- The Committee must be notified within 72 hours of any serious adverse event occurring at this site.
- Approval is ongoing, subject to satisfactory annual review. Investigators are responsible for providing an annual review to the RAH REC Executive Officer each anniversary of the final approval date using the Annual Review Form available at: <http://www.rah.sa.gov.au/rec/index.php> The REC must be advised with a report or in writing when this study approval is complete so that the file can be closed.

Yours sincerely,

Dr A Thornton
CHAIRMAN
RESEARCH ETHICS COMMITTEE

Appendix B: Interview Schedule

POSSIBLE Prompt questions For interviews

Opening questions:

Tell me what the word health means to you.

Tell me about your biggest health-related concern.

How often do you think about your health?

Where there is a focus on physical health:

So far we've focused on physical health – is there any other kinds of issues related to health that are important to you?

Perceptions and understanding of mental health:

Do you think of emotional functioning as a part of health?

Describe how emotional functioning has had an impact upon your life/health.

Mental health and its place in a medical service setting:

Do you ever talk to a doctor or other health professional about emotional difficulties?

Have they ever asked?

If not, what do you do when you have emotional difficulties?

Are there any issues that you feel you would like to talk to your doctor about but that are perhaps to difficult to discuss?

Comparisons between the self others:

Do you know how your partner might deal with these sorts of issues?

Do you know how your friends deal with these sorts of issues?

Imagine that one of your friends suffer from (a mental health problem). How do you think you would discover this? Would there be any indication that he was suffering?

Recent problems:

When was the last time you felt you had some emotional difficulty?

What was going on in your life at that time?

What helped you through this time?

Resolution:

Is there anything else that helps you deal with these kinds of emotional problems?

What prevents you from seeking help to cope with stress?

What changes would help you to deal with these issues?

Are you aware of (for example) Beyond Blue? What do you think about such organisations?

How would you feel contacting Beyond Blue or consulting doctors about issues regarding stress?

Do you currently take advantage of any services (such as Beyond Blue or governmental services, etc)? Why or why not?

Concluding:

Is there anything that you would like to add about your experiences with health, stress or coping?