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Research report

Men's use of positive strategies for preventing and managing depression: A qualitative investigation

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ABSTRACT

Background: One in eight men experience depression and men account for 75% of suicides. Previous research has focused on men's reluctance to seek help and use of unhelpful coping strategies.
Method: Thematic analysis was used on transcripts from 21 focus groups and 24 in-depth interviews focused on positive strategies men use to prevent and manage depression.
Results: In total, 168 men were recruited and the majority (63%) reported no current depression. Four major themes were identified, where men: (1) used a broad variety of positive strategies and made clear distinctions between prevention and management, (2) used strategies that were "typically masculine", as well as challenged expectations of manliness, (3) felt powerless in the face of suicide, and (4) had accumulated wisdom they felt was beneficial for others. Men specifically advised others to talk about problems. Prevention relied upon regular routines for "balance", while management relied upon "having a plan".
Limitations: The majority of the men were aged over 55 years and highly educated. Younger men or those without tertiary education may favour different strategies.
Conclusions: In contrast to using only unhelpful strategies, the men used a broad range of positive strategies and adapted their use depending on mood, symptom or problem severity. Use of positive strategies was sophisticated, nuanced, and often underlined by a guiding philosophy. Rather than simply reacting to problems, men actively engaged in preventing the development of depressed moods, and made conscious choices about when or how to take action. Clinical and public health implications are discussed.

1. Introduction

Worldwide, mental health and substance disorders are leading contributors to non-fatal disease, accounting for 183.9 million disability adjusted life years (Whiteford et al., 2013). Women are more likely than men to experience depression (Angst et al., 2002), while men are more likely to report substance use and externalising disorders (Addis, 2008). Mirroring global patterns, Australian women report higher rates of distress, but men report more than twice the rate of substance use problems (Australian Bureau of Statistics, 2012), and account for 75% of suicides (Australian Bureau of Statistics, 2014).

While debate continues about specific contributing factors to these gender differences (Nolen-Hoeksema, 2001; Parker and Brotchie, 2010; Piccinelli and Wilkinson, 2000), it is clear that men are at greater risk of suicide, men's depression can be "hidden" (Brownhill et al., 2005), or under-diagnosed by traditional measures (Danielsson and Johansson, 2005; Kilmartin, 2005), and men are less likely than women to seek help (Addis and Mahalik, 2003; Angst et al., 2002). Barriers to help-seeking include pervasive effects of personal shame and perceived stigma (Danielsson and Johansson, 2005; Hall and Partners, 2012; Heifner, 1997; Ritchie, 1999), apprehension about health professionals or what treatment "means" (Hoy, 2012; Mansfield et al., 2003), and the influence of masculine norms, which can limit emotional expression while emphasising self-sufficiency (Addis, 2008; Addis et al., 2010; Magovcevic and Addis, 2005). For some men, help-seeking is associated with a loss of personal identity (Hall and Partners, 2012) and may only be sought once they are "desperate" (Johnson et al., 2012).

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Furthermore, men use fewer coping strategies than women (Tamres et al., 2002), with recent research emphasising that men often cope with distress and depression using unhelpful strategies (Nolen-Hoeksema, 2012). A recent meta-ethnographic approach found that men expressed feelings of anger, hostility and aggression and subsequently employed strategies such as using drugs, alcohol, over-work or taking sexual risks, as ways to numb, avoid, or distract from depression (Addis, 2008; Brownhill et al., 2005; Hoy, 2012). Using ineffective coping strategies thus contributes to prolonged depression, lower detection, and treatment delays (Brownhill et al., 2005; Hausmann et al., 2008).

Some research has identified positive strategies men use to cope with depression, including taking time out, reframing negative events, problem solving, physical activities, meditation, and stronger social connections (Brownhill et al., 2005; Ramirez and Badger, 2014). However, men's maladaptive responses are a more predominant theme in the literature (Whittle et al., 2015), where more articles feature men's use of negative coping strategies than adaptive (Hoy, 2012). Where positive strategies are reported, their use is often acknowledged as occurring after a period of worsening symptoms, reluctance to seek help, and failure of strategies that only provided temporary relief (Chuick et al., 2009; Ramirez and Badger, 2014; Whittle et al., 2015).

Given this context, it is essential to consider how men manage depression naturally, or cope in the absence of clinical intervention. The present study therefore examined positive strategies identified by men as effective for preventing and managing depression.

2. Method

Data was collected using in-depth interviews and focus groups with men in New South Wales and Victoria, Australia with reporting informed by the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007). Focus groups were chosen owing to their strengths in exploring how and why people think about particular issues (Kitzinger, 1995), as well as their ability to stimulate interactions or increase participation of people who become engaged by group discussion (Kitzinger, 1994; Willis et al., 2009). Interviews were also offered in recognition that some participants may feel more comfortable discussing sensitive topics alone (Biddle et al., 2013). At each location, we aimed to recruit two interview participants and 12 focus group participants.

The research was led by two senior academics (JP, KW), with extensive experience and qualifications in psychiatric research, who provided training in risk management. All interviews and focus groups were conducted by one of three facilitators (EW, MP, AF), with previous research experience and academic qualifications in mental health.

2.1. Recruitment

Men were recruited from twelve metropolitan and non-metropolitan locations. The study was promoted via partner organisations, including Men's Sheds, community-based men's organisations and the lead institution's professional and digital networks. A local facilitator was employed at nine locations to publicise the study, recruit participants, arrange a venue, and identify local mental health services.

The recruitment flyer asked “What do you do when things get tough?” and avoided the words “depression” or “suicide” in order to attract men both with and without previous experience with depression. This approach was taken so as to identify as broad a range of positive strategies as possible, including: strategies used by men not in contact with health services, strategies particularly relevant to prevention among men who had not been depressed and strategies specific to management among those who had. Men were eligible if they were aged 18 years or more and could attend the specified time.

2.2. Procedures

Men participated in face-to-face interviews or focus group discussions with between six and eight participants and each location was attended by two facilitators. Participants were given an information sheet and gave signed consent. A questionnaire collected demographic information, assessed current depression via the Patient Health Questionnaire-9 (PHQ-9) (Kroenke et al., 2001), and asked about lifestyle and history of depression.

As recommended for discussions involving sensitive topics (Biddle et al., 2013), participant wellbeing was monitored. Men indicated on a visual analogue scale of 1 (*“as unhappy as I can be”*) to 10 (*“as happy as I can be”*) how they were feeling before the discussion/interview and again afterwards. All focus groups and interviews lasted between 45 and 90 min. The introduction emphasised confidentiality and that there were no right or wrong answers. Participants gave written feedback and were reimbursed AU$50 for their time and travel. All discussions were digitally recorded and transcribed.

A semi-structured interview schedule included “ice-breaker” questions to help participants talk generally about mental health, before moving to personalised questions about how they prevent, intervene early, and/or manage feeling down. Questions were open-ended, with specified prompts (Table 1). It was expected that men without previous depression experience may find questions about suicide confronting. As such, questions about suicide were asked in the third person with men able to disclose personal experiences if they chose.

2.3. Risk management

“At-risk” participants were identified by: (i) indicating current suicidal thinking (score higher than 0 on item ix of the PHQ-9); (ii) indicating current depression (PHQ-9 score of 19 or more); (iii) indicating worsening mood after participation (lower score on the visual analogue scale); or (iv) exhibiting distress and/or disclosing suicidal thinking during the discussion/interview. At-risk participants were followed up by a researcher at the close of discussion, who remained until their distress eased. For those requiring further follow-up, permission was sought to contact a family member and/or their GP. In rare cases of severe distress, the researcher contacted local services and the lead clinician (KW). All incidents were logged and reviewed.

All participants received a resources sheet for further information, referral or services and were able to choose three wallet-sized “coping cards” to keep. The cards contained short coping tips, or brief exercises (e.g. mindful breathing). Participants were contacted the following week, querying whether any concerns had arisen.

2.4. Data analysis

Thematic analysis was chosen to interrogate the data, owing to its flexibility (Aronson, 1995), rigour (Fereday and Muir-Cochrane, 2006) and common use in psychology research (Healey et al., 2009; Joffe and Yardley, 2004; Wright et al., 2012). Thematic analysis allows for the identification, analysis, interpretation and reporting of patterns within qualitative data (Tuckett, 2005), as well as recognises the reflexive role of the researcher in presenting the data (Mays and Pope, 2000).

For these analyses, a primarily inductive approach was