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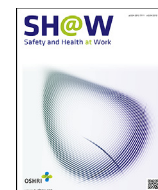

Review Article

Men, Work, and Mental Health: A Systematic Review of Depression in Male-dominated Industries and Occupations

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1. Introduction

Recent years have seen increasing interest in men's health, including mental health and wellbeing. There is growing recognition of the prevalence and implications of depression among men [1–3]. Although women have higher overall rates of depression [4], it is frequently unrecognized, undiagnosed, and untreated among men [5]. Given the significant costs associated with mental illness [6,7], poor mental health among men represents a large and preventable impost upon society.

Depression and bipolar disorders are among the main causes of disease and disability [8]. Mental health and wellbeing is an increasingly important issue. It is anticipated that by 2030 depressive disorders will become the number one cause of ill health and premature death world-wide, accounting for 6.2% of all disability-adjusted life years lost [7].

The prevalence of mental disorders comes at a substantial financial cost. It has been estimated that the annual economic cost of mental illness is at least £105 billion in England [9], $317 billion in the US [10], $51 billion in Canada [11], and $20 billion in Australia [12]. Depression and anxiety are also the most prevalent mental disorders in the working population [13] and a substantial proportion of costs associated with mental illness is due to lost workplace productivity. For example, annual lost productivity costs due to mental disorders are estimated at £30 billion in England [9], $51 billion in the US [14], $6.3 billion in Canada [15], and $5.9 billion in Australia [6]. Much of these lost productivity costs are directly associated with workforce absenteeism and presenteeism [16–18].

Traditional masculine norms and the stigma associated with mental illness can promote a culture whereby men are reluctant to acknowledge or seek help for mental health problems [7,19–22]. Although there is a higher prevalence of depression amongst women in the general population, men have lower levels of mental health literacy than women [23] and are less likely to visit their doctor [21,22], use mental health services [24], and discuss mental health issues [25]. Correspondingly, adverse consequences associated with poor mental health can be more severe among men, such as suicide [26].

Workplace factors can also contribute to poor mental health among men. Employment can promote wellbeing by providing regular activity, time structure, social contact, a sense of collective effort, and social identity [27]. However, the workplace can also be a source of psychological stress that can negatively affect employee mental health [28–33].

Male-dominated industries (i.e., those comprising >70% men) may be particularly problematic in this regard. Established risk factors for mental illness are commonly found in these industries, and include isolated/solitary work, excessive or irregular workloads, poor physical conditions, lack of control, and monotonous tasks [34]. Accordingly, workers in some Australian male-dominated industries have been found to have disproportionately high rates of depression and mood disorders [4]. However, it is uncertain whether the prevalence of depression among men in male-dominated industries is consistent across countries.

Given the potential impact of working conditions upon mental health, workplace health promotion programs and interventions are increasingly being implemented to prevent/minimize the emergence of problems and support workers with mental health

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issues. Such workplace programs are particularly relevant for mental health promotion targeting men.

The workplace provides ready access to large numbers of men and contains existing infrastructure and frameworks that can support mental health and wellbeing strategies. In addition, addressing mental health issues as part of wider occupational health, safety and wellbeing programs may create workplace norms that reduce stigma and facilitate help-seeking. Workplace programs can also target other barriers to mental health help-seeking behavior such as low levels of mental health literacy [35,36]. Moreover, the workplace offers an opportunity to develop tailored strategies that target specific high risk industries and occupations.

Such tailored strategies may be particularly beneficial for workers in male-dominated industries, due to the high prevalence of mental health problems in combination with low mental health literacy and a reluctance to seek help. While research is limited, there is some evidence that interventions in male-dominated industries can have a positive impact on the mental health of workers, particularly for high prevalence low severity disorders such as depression [37,38].

However, the development of tailored workplace strategies for men is hampered by a lack of prevalence data identifying high-risk workforce groups. While prevalence rates for depression are known to vary across different occupations and industries [39,40], it is not clear whether rates of these disorders are consistently elevated in workforce groups where men predominate.

A better understanding of the prevalence of depression in industries and occupations with a high proportion of men could inform the development of appropriate policies and tailored workplace mental health interventions. However, to date, no research has systematically examined the prevalence rates of common mental disorders, such as depression, amongst male workers employed in male-dominated workforce groups.

In order to address this issue, a systematic review of literature was undertaken to determine the prevalence of depression amongst men employed in male-dominated industries and occupations. The review forms part of a larger program of work exploring risk factors for mental illness in male-dominated industries and effective intervention approaches [28,37]. Specifically, the following research questions were investigated:

Q1. Is depression among male workers in male-dominated industries and occupations greater than in comparable populations? Comparable populations are defined as general population/total workforce/all male workers.

Q2. Is depression more prevalent in particular male-dominated industry/occupational groups?

2. Materials and methods

A systematic literature search was undertaken to identify and assess the findings and methodological rigor of relevant studies.

2.1. Inclusion and exclusion criteria

Studies were included in the review if they examined paid workers employed in “male-dominated” industries or occupations [agriculture (forestry and fishing), construction, manufacturing, mining, transport, or utilities); administered validated indicators of depression, or related disorders; and were published in English between January 1990 and June 2012. Studies were excluded if they examined volunteers or migrant workers who were not citizens, or were government or industry reports [41] (Table 1).

Male-dominated industries and occupations were defined as those where at least 70% of the civilian workforce were men. In Australia, male-dominated industries include: agriculture (forestry, fishing, and farming), construction, manufacturing, mining, transport, and utilities (electricity, gas, water supply, and waste management) [42]. Male-dominated occupations include: farming and forestry workers, laborers, production workers, tradespersons, and transport workers [43]. Similar industries and occupations are also classified as male-dominated in the USA [44,45] and most European countries [46]. Defense and emergency services (police, ambulance, fire) were excluded from the study due to the potential for confounding. The manifestation and presentation of depression is likely to be much more complex, given the nature of the work and exposure to trauma in these industries/occupations and warrant separate consideration.

Data on the number and proportion of men employed in male-dominated industries and occupations for countries where studies were located are provided in Table 2.

The focus of the review was symptoms of depression that may require intervention. Symptoms of depression were indicated by positive screens on validated self-report instruments (e.g., Center for Epidemiologic Studies Depression Scale, Depression, Anxiety, and Stress Scale, and Kessler 6/10), or clinician or trained researcher administration of validated clinical instruments (e.g., Clinical Interview Schedule, Mini International Neuropsychiatric Interview, University of Michigan Composite International Diagnostic Interview). The former are designed to detect the likelihood of depression in a person, whilst the latter gather more detailed information from individuals on the potential presence and seriousness of depression. As these instruments are highly correlated with a diagnosis, we have used the general term “depression” [28]. Prevalence data for depression were subsequently extracted/calculated from the results section of each included study. Further details of the measures used are shown in Table 3.

Table 1
Study inclusion and exclusion criteria

Criteria	Included	Excluded
Male-dominated industries and or occupations	Agriculture, forestry & fishing; construction; manufacturing; mining; transport; utilities	Other industries Migrant workers who are not citizens
Language	English	Non-English
Sex	Any sex	NA
Mental Health	Depression; psychological distress symptoms, and conditions	Not depression
Type of work	Paid work in developed countries including full-time, part-time, casual, temporary/contract/transient; formal work	Volunteer work
Types of research	Primary research studies published in the English language	Nonprimary research (e.g., literature reviews; government reports; industry reports), and studies not published in the English language

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