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The purpose of this study was to holistically explore the life patterning of men with depression from a unitary nursing perspective. A unitary appreciative inquiry method was used to cooperatively explore depression with six men between the ages of 21 and 60. The stories that the men provided illuminated individual and group life patterning offering insights regarding the needs of men living with depression extending beyond clinical approaches. Findings suggest that men suffer with depression for years before seeking professional help, and tend to rely on primary health care providers, rather than specialists. The men in the study described unique ways that men experience depression that are gender-specific. In seeking help, the men in this study preferred solutions that were simple and rapid. Implications of this study for nursing include the need for understanding male depression as having unique characteristics that require a tailoring of approaches. Most notably, men are seeking help outside the traditional mental health care system. Nurses and other health care professionals need to attune interventions to men that provide them with an opportunity to share the non-clinical aspects of their experience. Public health education needs to be designed to emphasize that depression is not viewed as a personal flaw or weakness.

LIFE PATTERNING OF MEN  
WITH DEPRESSION

by

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Approved by

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Committee Chair

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In Dedication To

..... the many male clients I have worked with over the years who have taught me so much and that have made me aware of hidden depression in men.

..... the courageous men who participated in this study not only sharing their stories about depression but who universally expressed their desire to help other men with depression.

## APPROVAL PAGE

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## PREFACE

I have been a practicing nurse for over thirty years. I still feel immense sadness when I talk to someone about their physical illness or mental anguish. I am in awe that people face catastrophic devastation with such courage. I have learned more from my patients than ever from a book. Sometimes when people relate their stories I want to cry; I want to rage. In truth, the best I can do is stay very still, I listen, I support. That is why I became a psychiatric nurse. I only hope that I have touched their lives in some small helpful manner.

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## **CHAPTER I**

### **INTRODUCTION**

#### **Life Patterning of Men with Depression**

This is a descriptive exploratory study examining the life patterning of men with depression based on unitary appreciative inquiry (UAI; Cowling, 2004; 2007). As a research method UAI allows the researcher to move towards capturing the wholeness of these men's lives and their health seeking behaviors. Essential to UAI is the inclusion of depressed men as research partners. Their contributions are appreciated in absolute wholeness which removes the emphasis on confining diagnostic categories (Cowling, 2004). This facilitates a research process of viewing men in relation with their depression. Specific areas explored within the wholeness of life patterning in male depression were perceptions, experiences, and expressions.

Information includes reports by a voluntary sample of men who self-identify as wanting to share personal knowledge about their depression. Data are from individual interviews. A short roster of open ended questions provides structure to the research, promotes discussion, and allows for inclusion of additional participant contributions. The conceptual framework supporting this work stems from the belief that in order to reach a deeper understanding of the struggle men endure in the course of living with depression; they must be the center of the research (Cowling, 2004; Sacks, 2006).

Depression affects 5.5 million men over the age of 18 in the United States every year (SAMHSA, 2010). Also 9-12% of men experience major depression at some time in their lives, and on any given day about 3% of men have symptoms meeting the standard criteria for major depression (Good, Thomsons, & Brathwaite, 2005). Yet, multiple factors contribute to depression in men remaining a hidden epidemic. Men suffer without acknowledging their pain or asking for support (Brooks, 2001; Brownhill, Wilhelm, Barclay, & Schmied, 2005). The interplay between gender specific masculine roles and male physical characteristics combine to generate additional challenges for men with depression (Brooks, 2001). Men are reluctant to acknowledge symptoms of depression or to enter treatment for depression (Mahalik, Good, & Englar-Carlson, 2003; O'Brien, Hunt, & Hart, 2005). Gender and social role expectations dictate acceptable behaviors for men proscribing emotional awareness and expression (Cochran & Rabinowitz, 2003). Internalized male roles include self-reliance, overcoming adversity, and moving through pain (Addis & Mahalik, 2003).

Traditionally, men have been diagnosed with clinical depression using standard criteria. The classic clinical reference for diagnosing depression is the Diagnostic and Statistical Manual IV (DSM-IV-TR; American Psychological Association [APA], 2000). It provides clinicians with specific diagnostic criteria to use as guidelines for making a diagnosis of major depression. A classic depression screening tool is the Beck Depression Inventory (BDI). The BDI measures four dimensions of depression: cognitive, behavioral, affective, and somatic (Beck, Steer, & Garbin, 1988). The standard tools work well in identifying depression in men already in treatment. Men who are in

treatment for depression report traditional depressive symptoms: depressed mood, suicidal ideation, disturbances in sleep and appetite, low energy, anhedonia, poor concentration, psychomotor retardation and guilt (Cochran & Rabinowitz, 2003).

Some researchers continue to question if traditional screens initially identify depressed men adequately. Several researchers have attempted to develop screening tools to use only with men (Brownhill, Wilhelm, Eliovson, & Waterhouse, 2003; Zierau, Bille, Rutz, & Bech, 2002). To date a statistically significant male depression rating scale has not emerged. Other researchers suggested men initially be screened for depression using standard criteria and are then further evaluated about gender sensitive behaviors associated with male depression (Cochran & Rabinowitz, 2003).

Research supports a number of differences in how men deal with feelings. Men express their depression with clusters of behavior including increased interpersonal conflict, work-related problems, restricted emotional responses, rumination, alcohol and drug abuse, and antisocial behaviors (Möller-Leimkühler, Bottlender, Strauß, & Rutz, 2004). These behaviors often mask male depression. Men demonstrate differences in how they initially approach depression. They will deny the symptoms longer. Depression is seen as a humiliating condition that challenges their core sense of masculinity (Addis & Mahalik, 2003). Men see depression as a personal failure and not as an illness (O'Brien et al., 2005). Self-reliance and self-control are core male values which lead men to attempt to solve the problem of depression alone. Men tend to internalize depressed feelings and are reluctant to express them.

Helping men with depression is difficult because of the internal and external constraints against men acknowledging depression. The constellation of internal beliefs and external societal pressures does not support men with depression getting help (Emslie, Ridge, Ziebland, & Hunt, 2006). Further, there are differences in how men seek help and access health care which are influenced by their social context and masculine based belief system. If men decide to get professional treatment for depression, they seek it later in the course of the disease after prolonged and debilitating suffering. When men finally seek help, the depressive illness is more entrenched and more resistant to treatment. A protracted illness delays the benefits of intervention. Delay in a rapid treatment response can be intolerable for men who are conditioned to gain mastery, maintain control, and eschew dependency. For men suicide involves being active and decisive. It looms as an honorable and acceptable way to regain control and end suffering.

Lacking in the literature is an in-depth, gender-specific understanding of the holistic nature of the lives of men dealing with depression. Studies have quantified and isolated symptoms that define clinical depression and have compared evidence based treatments in the broader human experience. Research with all male samples has isolated specific factors present in men with depression. The National Institute of Mental Health and the W. K. Kellogg Foundation have called for gender specific research about men with depression (NIMH, 2005; W. K. Kellogg Foundation, 2004).

Knowledge about the experience of depression, a personal and internal affliction, is hidden within individuals. Both qualitative and quantitative researches have failed to

provide a comprehensive understanding of the wholeness of the lives of men with depression. How do men with depression perceive and experience their lives and their attempts to get help through the cloak of depression? What patterns emerge as men with depression express living with depression? To help develop new knowledge about life patterning of men with depression, men need to be active participants in the research process. Without this client centered knowledge it is difficult to develop interventions to help increase awareness about depression that lead to rapid treatment.

### **Men with Depression as the Population of Study**

The overall range of this population cannot be limited by age, race, culture, or socioeconomic status. The World Health Organization identifies depression as one of the top ten leading cause of disability as measured by actual years lived with disability. It predicts that by the year 2030 depression will be one of the top three contributors to the global burden of disease as measured by premature deaths and lost years of productive life (World Health Organization, 2012). The National Institute of Mental Health initiated a public health campaign called Real Men Real Depression (NIMH, 2005). This effort was aimed at helping men and health care providers understand that men from all walks of life, all cultures, and all ethnicities get depression.

For the purposes of this study participants consisted of adult males over 21 years of age. These men were recruited by public requests for research participants who had information they wanted to share about how they lived with depression. The convenience sample was selected from men without limitations for race or culture who were capable of relating their story in spoken English.

## **Gender and Depression**

In a study about men with depression, it is worth examining differences and similarities between men and women with depression. This knowledge helps to refine diagnosis and improve treatment for both of these populations. Rates of women diagnosed with depression have been consistently higher than men by 2:1 in studies ranging from smaller community samples to ones that involved large multi-national samples (Marcus et al., 2005; Romans, Tyas, Cohen, & Silverstone, 2007; Seedat et al., 2009). Women have an earlier onset of depressive disorders 24.3 years, longer episodes of depression 22.9 months, and less suicidal ideation 45%. They display more observable signs of depression and anxiety. Women present with increased tearfulness, sleep and appetite disturbances, somatic symptoms, and bulimia (Clarke & van Amerom, 2008). They identify signs of depression earlier and enter treatment with milder forms of depression. Overall more women (68%) participate in outpatient treatment and they stay in all types of treatment 20% longer than men (Kessing, 2005). Women identify causes of depression as more personal and nested in relationship problems. Women tend to turn depression into anger. They often direct the anger at themselves. They are interested in self-help, alternative treatments, and use support from friends and family (Clarke & van Amerom, 2008). Daughtry and Pault (2006) found that women had 46 different coping strategies, including dealing with power issues, passive and self-defeating behaviors, and support seeking.

The average age of male onset depression is 26.5 years, episodes average 17.3 months, and 55% of men think about suicide and self-harm (Marcus et al., 2005). Men

with feelings of sadness and frustration are more apt to externalize their discomfort. They associate depression with external events. More men act out their depression with oppositional behaviors, substance use, and crime. They see depression as a physical illness and are more reliant on pharmacology. Treatment is sought because it is the responsible thing to do (Seedat et al., 2009). Men utilize more active coping interventions, rely more on individual problem solving, and make more attempts to deaden the pain. Men had 39 different coping strategies, 7 less than women (Daughtry & Paulk, 2006). Men are slower to identify symptoms as depression, enter treatment with more severe levels of depression, and fewer men (64%) engage in outpatient treatment. Men think about suicide more. They see it as an active solution to their pain. Men are 2 to 4 times more likely to complete the act of suicide and end their own lives. The higher success rate may be due to men using more lethal forms of suicide and increased severity of untreated depression (Marcus et al., 2005).

Essentially depression is the same illness for men and women. They share many of the precursors of depression and life stressors. Research showed three areas in which men and women were different. Men were more affected by divorce, separation, and job issues, while women were sensitive to more diverse relationship problems (Kendler, Thornton, & Prescott, 2001). However by the time men and women were diagnosed with depression and in active treatment, no significant differences emerge in the sensitivity to precursors to depression or to presence of social support (Dalgard et al., 2006). Marcus et al. (2005) found no gender differences in symptom severity, length of illness, or functional impairment. There were no significant differences in age, education, or

severity (Schoenbaum, Sherbourne, & Wells, 2005). Kessing (2005) concluded there were no differences between men and women in the severity of their depressive, psychotic, or melancholic symptoms. Men and women also respond equally well to professional interventions including psychotherapy and chemotherapy (Rochlen & Hoyer, 2005). These objective findings provide a solid basis for understanding depression, but have not yet succeeded in resolving subjective and debilitating differences in how men and women deal with depression.

### **Purpose of this Study and Specific Aims**

The purpose of the study is to explore the life patterning of men who have lived with depression. This will be accomplished through illuminating facets of information about how depressed men perceive, experience, and express their lives within the nursing context of Rogers's science of unitary human beings (SUHB). This is supported by the use of unitary appreciative inquiry, a research method which is congruent with the ontological and epistemological principles of Rogers's nursing science (Cowling, 2004.)

The specific aims of the study are to:

1. Illuminate the life patterning of wholeness associated with depression as perceived, experienced, and expressed in men.
2. Contribute to unitary nursing knowledge about men's experience of depression and health.
3. Refine Cowling's unitary appreciative inquiry methodology as an approach for nurses to develop a distinctive body of nursing knowledge.

## **Research Questions**

The research questions are: What is the individual life patterning of men self-identified as depressed as experienced, perceived, and expressed? What is the mutual life patterning of men self-identified as depressed as experienced, perceived, and expressed? What are the life patterning features of men seeking help for their depression?

## **Assumptions**

The study is based on the following assumptions:

1. The male response to depression contains additional diagnostic symptoms, is inhibited by men's reluctance to enter evidence based therapeutic regimes, and is affected by men's resistance to public health educational programs.
2. Existing research is fragmented and does not portray a holistic representation of how men deal with depression.
3. Standardized depression screens and current diagnostic criteria for major depression are not expansive enough to provide early detection of male depression.
4. Consequences of prior assumptions for depressed men result in severe dysfunction, prolonged suffering, and early death.

## **Definition of Terms**

*Depression*—A persistent debilitating state of feeling sad, alone, apart, hopeless, helpless, and guilty. Depression includes a full range of depressive illnesses with a wide emotional spectrum including, grief, impaired capacity to problem solve, loss of self-confidence, and a belief that the condition is endless.

*Illuminate*—Bring to the surface for study information that was previously undisclosed, to provide light or insight on a subject and therefore make it visible and accessible.

*Experience*—Includes raw encounters with life associated with strong sensations, awareness as a source of knowledge, and self-encounter.

*Expression*—Includes internal and external personal expression, meanings attached to events. Expression is the overt manifestation of the combination of experience and perception and is unique to an individual.

*Facets of pattern*—Sources of pattern information, not separate parts which are contained in pattern manifestation. Pattern information is continuous and changing. It is synthesized in a process with a deliberate goal to improve health status (Barrett, 1988; Cowling, 2000).

*Perception*—Includes conscious knowing reflecting and making sense in the midst of living experience.

### **Author Bias**

Early in this research project several issues emerged. The first was whether men with depression would feel comfortable sharing personal information with a female researcher. I answered that question based on my experience of 25 years of psychiatric nursing. The researcher has an advanced practice nurse in psychiatric mental health and has engaged in clinical encounters with men willing and relieved to share their experiences of depression. The second was that several of the seminal journal articles were by women researchers (Heifner, 1997; Warren, 1983). It was as if women were

aware of depressive issues in men earlier than male researchers. Somehow their inquiries opened the door to looking at men with depression as an important population.

### **A Nursing Theoretical Orientation**

Florence Nightingale's seminal work in 1869 identified the domain of nursing as distinct from medicine, concerned with reparative health promotion, and creating a suitable environment for patient healing. Her book presented her thoughts on what nursing is and what it is not (Nightingale, 1969). Nightingale encouraged nurses to develop empirical knowledge through observation and documentation about what really engendered health and healing. She wrote "The very elements of nursing are all but unknown" (Nightingale, 1969, p. 8). Her prophetic work began a quest which inspired nurses to discover knowledge that is specific to those elements unique to the essence of nursing. This vision established the domain of nursing and laid the path for development into a discipline. A discipline is "Characterized by a unique perspective, a distinct way of viewing all phenomena, which ultimately defines the limits and nature of its inquiry" (Donaldson & Crowley, 1986, p. 242).

Nursing, a humanistic and empirical science is distinct from other disciplines. Nursing science has the purpose of describing, explaining, and predicting phenomena central to the domain of nursing (Rogers, 1970). Rogers (1988) wrote that a science needs a language that is specific to its discipline. Nursing scholars acknowledge that nursing science has drawn heavily from other disciplines. At times this practice has been necessary and acceptable (Fawcett & Alligood, 2005). "Theories from other disciplines must be tested for usefulness in nursing" (Chinn & Kramer, 1999, p. 34). Watson (1981)

proposed that received knowledge does not become nursing knowledge until it is examined under nursing conditions. This process allows nurses to synthesize information through the lens of a nursing conceptual framework. In order for nursing to mature as a separate discipline, it must do research using nursing theories which are based epistemologically and ontologically within the domain of nursing, human beings, their environment, and health (Butcher, 1994; Fawcett, 1986).

Rogers's science of unitary human beings emerged from creative and original thought about the essence of nursing (Rogers, 1970). With exceptional foresight, Rogers's theory opened up acceptance for the use of multiple pathways of assessment and knowing which lead to development of richer nursing knowledge (Carper, 1986; Chinn & Kramer, 1999). Rogers realized that a sentient unified whole human being functions as an open system and may best be understood through the manifestations of patterns rather than as an assembly of parts (Rogers, 1970).

## **Patterning**

Margaret Newman (2002) identified pattern recognition as the process which unites the art and the science of nursing. Viewing information through the lens of patterning opens up ways of understanding that integrate all aspects of human existence, thus eliminating false dichotomies between the physical, mental, social, or spiritual realms. Included in pattern recognition is the total sum of prior accumulated knowledge as well as the capture of the essence of the current nurse-client health related interaction. The nurse-client process is carried out within this awareness of the whole and does not include fragmentation between the art and science of nursing, man and his environment,

or the physical and mental processes of life. The knowledge obtained from research using pattern recognition both integrates and transcends previous knowledge (Cowling, 2007). The nursing care delivered using pattern recognition is participatory and transformative for the client who moves to another stage through the process of being known (Cowling, 2004, 2007; Newman, 2002).

Pattern recognition acknowledges that each person is whole at any given moment in time. This perspective accepts that pattern emerges as a manifestation of things which cannot be directly observed. Pattern is demonstrated in objective and subjective ways on four levels: “physical/material, emotional/mental, social/cultural, and spiritual/mystical” (Cowling, 2007, p. 62). This perspective provides researchers with a new way of generating knowledge through unitary appreciation inquiry (Cowling, 2001, 2007). The starting premise is that the human being is whole and that any seeming part in fact contains and reflects the whole like a holographic image (Cowling, 2007). “Unitary appreciative inquiry has a primary focus of seeking to know the wholeness, uniqueness, and essence of human life as a context for understanding phenomena and conditions of concern to nursing and guiding action in practice” (Cowling, 2001, p. 33.) The portals to a deeper understanding of the human condition are observed by three equal and commingling indicators. They are reflected in how people perceive, experience, and express their condition, and are to be appreciated as a single pattern manifestation (Cowling, 2007).

A research study about patterning in male depression opens up the possibility of developing intensely personal and in-depth knowledge about how men relate to

depression. Unitary appreciative inquiry encourages the incorporation of multiple ways of knowing, and active client participation to uncover strands of information that results in the syntheses of meaningful knowledge.

### **Significance to Nursing**

The data produced by this study contributes to the general fund of knowledge about men with depression. The discipline of nursing has been entrusted by the public with providing ethical health care with beneficence during critical life events. Nursing is charged with providing care in the most intimate situations and maintaining confidentiality. Nursing science “is mandated by society not only to develop and disseminate nursing knowledge but also to use that knowledge to improve the well-being of human beings” (Fawcett, 2005, p. 589). Fawcett (2005) cautioned nurses that their ability to continue to exist and thrive as a unique discipline depends on the use of explicit nursing theories to guide research and practice. Nursing science makes a unique contribution to knowledge about human well-being from the perspective of the discipline of nursing.

Health promotion and the well-being of all people are within domain of nursing (Rogers, 1992), therefore understanding the phenomena of male depression is worthy of nursing research. This study supports the notion that new nursing knowledge is best developed using conceptual models and theories that are based in nursing science. There are no current studies about male depression from a unitary appreciative inquiry/nursing science perspective. Basing this research on Rogers’ science of unitary human beings provides expanded insight about men and depression.

## **Summary**

There is a gap in general and nursing knowledge about the subject of the wholeness of men with depression. A search of the literature did not reveal information about holistic male centered depression. This study about men with depression offers the opportunity to synthesize new knowledge that is credible, dependable, and confirmable because it is based on interviews with men who have lived with depression. Information which emerged from direct interviews with men is transferable to other men with depression. This study provides new knowledge to enhance the practice of providers caring for men with depression. A new way of looking at the patterns of the lives of men with depression leads to ways to motivate men to acknowledge their depression earlier in the course of their illness, accept treatment, and preserve their self-efficacy.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **Introduction**

This chapter reviewed the current state of knowledge about men and depression. The discussion included why researchers have chosen to study men with depression as a separate population, relevant studies, and gender issues. An attempt was made to include original papers and studies. The search included published studies available in the literature and catalogued in Pub Med, CINAHL, and EBSCO. Topics researched included men and depression, gender differences in depression, and unitary appreciative inquiry. The topics were found in psychology, medical, social work, and nursing journals. The review began with early observations of the paths men followed during the course of depression to the evolution of a body of knowledge about men and depression. The review was organized in a sequential order with earlier works presented first. Some early works were included even though they exceeded standard time parameters for research papers. They were cited here for two reasons. First, they established a strong foundation for continued research. Second, the existing research on men and depression was scant. Nursing research on the topic was almost non-existent.

The review of literature about men and depression was separated into three sections, identified by Polit and Beck (2004), related to research purposes: Identification and Description, Exploration, and Explanation. The first section, Identification and

Description, contained studies in the beginning stages of the investigation of men and depression. Researchers showed awareness that empirical evidence, clinical encounters, common assumptions, and the existing knowledge about depression failed to provide a complete picture of depressed men. Identification was the process of uncovering a new facet of depression and giving it a name. Description followed as researchers identified dimensions, prevalence, characteristics, variations, and the importance of depression in men. The second section, Exploration, looked at antecedents and factors related to the topic. Researchers attempted to examine the full nature and the development of the area of interest. The third section was Explanation. These studies attempted to explain underlying factors which contributed to men with depression. The focus was on how it occurred, why it occurred, how it worked, and what it meant? Consistent with research as an active and ongoing process with each new study confirming or making incremental additions to the existing body of knowledge, studies in these three sections often overlap. As each inquiry led to new questions, there was also a continuous integration of data collected from both qualitative and quantitative methods.

An enduring assumption about depression has been that the disorder was more prevalent in females than in males (Marcus et al., 2005). Another was that men were somehow immunized against depression (Cochran & Rabinowitz, 2003). A research conundrum has been to resolve conflicting data in which actuarial numbers showed men died from suicide 4 times more often than women. These numbers have remained unchanged in spite of evidence showing twice as many women as men suffer from depression, and that depressive illness was a strong precursor to suicide (Emslie et al.,

2006). When a public health campaign to lower the suicide rate in the general population was effective in lowering suicide rates for women but did not lower rates for men (Winkler et al., 2004), researchers asked if there was a separate male depressive syndrome with its own diagnostic criteria (Möller-Leimkühler et al., 2004). Attempts have been made to isolate depression in men with discrete criteria like substance abuse and acting out behaviors (Zierau et al., 2002; Brownhill et al., 2003).

There was a new awareness that even though a disorder was similar physiologically in males and females symptoms and diagnostic criteria may be different. This was the case with myocardial infarctions. When the medical knowledge surrounding heart attacks was based primarily on men experiencing heart attacks, it was accepted medical knowledge that women rarely experienced them. The diagnostic criteria were based on how men presented with heart attacks. Doctors looked for the established symptoms. Women did not present with the same symptoms and missed diagnosis proved fatal. Researchers established that depression was the same illness in men and women. This raised several questions. First, if depression was the same illness in men and women, was it being experienced differently in men and women? Second, would clinicians be more effective using additional gender specific diagnostic techniques and treatment interventions?

Most research on depression has been done on women (Emslie et al., 2006). This was due to the higher rate of diagnosis of depression in women. It has also led to a depression symptom constellation containing conditions most often experienced and reported by women. This created a circular process with depressed women describing

their symptoms, which led to diagnostic criteria for depression based on women's experience. Then persons displaying these criteria were diagnosed as depressed. The result was that more women were being diagnosed with depression. Clinicians who worked with men have been aware that depressed men may not meet the typical criteria for depression (Brownhill et al., 2003; Cochran & Rabinowitz, 2003).

### **Identification and Description**

Four studies were presented in this section. Researchers questioned, if common diagnostic practices truly captured the full range of depression in men. Underlying questions included: was depression in men under diagnosed, under treated, and was it responsive to standard therapeutic interventions (Good et al., 2005)? Research methods included grounded theory, focus groups, and direct interviews. These qualitative research methods suggested researchers thought they knew little about how men experienced depression. They wanted to be open to knowledge that emerged from their samples, to ask "What is happening? What are people doing?" (Charmaz, 2005, p. 514).

As recently as 1997, Heifner wrote that she could not find any qualitative research about the experience of male depression. She interviewed 14 men who had been diagnosed with major depression. She found depressed men held rigid ideas about traditional gender roles. They believed men were supposed to be strong, unemotional, and bear the weight of pain. Men also expressed masculine-based ideals related to performance. They wanted to be the best and work the hardest. They maintained emotional distance from others. They developed a hidden self and told lies to maintain a strong persona. Men felt depression caused them to lose control over their lives. They

could not do their usual activities. Depression was experienced as a physical force pressing down on them. They engaged in increased substance use and understood suicide as a way to regain control. All the men had delayed seeking professional help. When they did get help they found ways to maintain their masculinity and legitimize treatment. The men in this sample voiced the opinion that more men suffered from depression than get treatment.

Brownhill et al. (2005) explored men's experience of depression. The researchers conducted 10 focus groups. The sample consisted of seventy-seven men in 6 groups and 25 women in 4 groups. Five themes emerged that were unique to the male sample. These themes were incorporated into a 5 stage model for hidden depression in men. During the first stage, men tried to avoid the negative feelings associated with depression. They tried to forget and deny problems and hoped they would go away. In the second stage, men engaged in activities to alleviate the feelings by stepping up involvement in work, exercise, or hobbies. The third stage of dealing with depression included trying to deaden the feelings and feel numb. Men in this stage might turn to drug and alcohol use. As the depression persisted and time passed men started to cope by acting out their pain. They tried to escape it. Men engaged in increased risk taking behaviors, increased drug and alcohol use and gambling. The fourth stage was a time when depressed men begin to engage in behaviors that hurt themselves and others. The last stage was the most dangerous. Men began to step over the line and engage in deliberate attempts to hurt themselves or commit suicide. The researchers concluded that depression in men may be hidden even though the experience of depression was the same for both men and women,

because men do not express it in symptoms assessed on routine depression screens. They recommended looking into men's subjective experiences of depression.

The third study looked at how masculine identity affected the way men access health care. O'Brien et al. (2005) held 14 focus groups with 55 men. Two initial questions asked if men talked with other men about their health and what was their experience seeking health care. Older men who had experienced a serious physical illness were the most likely to talk about their health with other men. Men needed to have a good enough reason to see a doctor. Good enough reasons included a heart attack, a visible injury, a condition that would prevent a man from doing his job or providing for his family, sexual problems, or a condition confirmed by a respected peer as being worthy of attention. Men were especially reluctant to seek help for depression. They feared castigation from other males because they would be seen as weak or less masculine. Good reasons to seek help with emotional problems included bereavement, unmitigated depression, and stress. In each case a man was supposed to have made an extended effort to get over his depression and should have endured prolonged suffering. The men in the sample agreed that they preferred not to complain about minor conditions, waste a clinician's time, and to generally move through their pain. The researchers concluded that men with mental health issues were at the highest risk for not getting help.

In a secondary analysis of interviews conducted with 16 men, Emslie et al. (2006) sought answers to the question, "How does depression influence the male gender identity?" (p. 2248). Depression was seen as the destruction of the former self. Data showed that as men recovered, they viewed the experience of depression through a lens

of hegemony. Men incorporated masculine interpretations into their recovery. The men reconstructed a new sense of self. Some masculine themes expressed were being one of the boys again, regaining control, and being responsible to others. Suicide was seen as a way to regain control over the depression. It involved courage and was not seen as cowardly. Having endured the pain of depression was seen as a masculine thing to do. Some men voiced the belief that the depression had made them different, more sensitive, or smarter and that was acceptable. The authors concluded that it was important for men to value a reconstructed sense of self and masculinity as part of healing. These studies supported the idea that men worked hard to defend themselves against depression or any open display of depression. They shied away from calling it depression and thought of it as stress. They tried to hide it by working harder, denying it, or covering it with increased risk taking. Men actively deadened their feelings and delayed seeking help. Men with depression were at high risk for not getting adequate mental health interventions. All of these reasons have contributed to the difficulty clinicians and researchers have had diagnosing, treating, and studying depression in men.

### **Exploration**

In this section the studies were designed to answer questions related to the possible antecedents, evolution, and process of male depression. Researchers continued to draw from the general population and study samples included men and women. During research exploration both qualitative and quantitative methods provided avenues to gather information. Part of exploration sought to understand the full nature of the topic. The main questions underlying research about men and depression were: What are researchers

and clinicians missing? Why numbers were consistently lower for depressed men than for depressed women? Were women seeking help and getting diagnosed with depression while men engaged in risky behaviors and suffered legal consequences for substance use and dangerous acting out?

Cochran and Rabinowitz (2003) addressed some of these issues when they recommended a more inclusive depression screening tool for use with men. They acknowledged that unidentified and untreated depression in men led to a decreased quality of life for these individuals and at times held fatal consequences. They accepted as fact that depression in men and women share the same primary symptoms and course of illness. The difficulties arose in assessing and treating depression in men. Symptom identification was colored by social and cultural constraints against men showing emotions and seeking help. They made recommendations to extend the initial depression screen for men. The beginning assessment would remain the standard Diagnostic and Statistical Manual criteria. Additional areas that should be assessed included gender-role strain, increased episodes of anger, conflict, and violence, incongruence between stated content and emotions, and increased substance use. Recommendations for therapy included a cultural sensitivity to internalized masculine roles.

The STAR\*D (Sequenced Treatment Alternatives to Relieve Depression) study was a nationwide project funded by the National Institute of Mental Health (NIMH) (Marcus et al., 2005). The goal of the study was to determine the effectiveness of various treatment methods for resistant depression. One study analyzed the data for possible gender differences related to depression. The study included 1,500 participants. Findings

showed women were subject to earlier onsets of depression, longer episodes of depression, and coexistent bulimia, anxiety, and somatoform disorders. Women scored 20.6% and men scored 13.7% for a cluster of symptoms described as atypical depression. Atypical depression was constructed of mood reactivity plus two more symptoms from the following group: significant weight gain, increased appetite, hypersomnia, leaden paralysis, or interpersonal sensitivity (Marcus et al., 2005). One could question if this framing of atypical depression was biased in favor of uncovering female depression. More often literature about men and depression has described atypical symptoms of depression as increased substance abuse, risky behaviors, and acting out behaviors. This study showed depressed men engaged in more hazardous drinking and drug use than women by 19%/8.3% and 29.4%/26.3% respectively. Men also demonstrated increased comorbidities in psychomotor agitation and suicidal ideation. Researchers suggested that depression should be looked at between genders and in relationship to co-morbid conditions (Marcus et al., 2005).

The lingering problem of consistently high completed suicide rates in men was examined in a study of impulsive and aggressive behaviors prior to death. An initial assumption has been that depression was a strong predictor of suicidal behaviors. More specifically depression with co-morbid mood disorders accounted for 60% of completed suicides (Dumais et al., 2005). Men who completed the suicide act were more likely to have two or more co-morbid Axis I diagnoses. Depression with only a co-morbid anxiety disorder was not predictive of completed suicide. Dependence and abuse of alcohol in the six months prior to an attempt contributed to a completed suicide. Aggressive and

impulsive behaviors were present more often in younger men. Alone they were not direct predictors of completed suicide. When combined with cluster B personality disorder traits, aggression and impulsivity became predictive of completed suicide. Included in the cluster B criteria are irritability, aggressiveness, and a disregard for self and others (DSM-IV-TR; APA, 2000). In men, cluster B personality traits and misuse of alcohol in the last six months provided two independent predictors for completed suicide (Dumais et al., 2005). Overall this study helped to answer part of the question about men's higher suicide rate. Men were more likely to act out their depression with increased alcohol use, aggression, and impulsive behaviors, which were found to be predictors of suicide.

Kilmartin (2005) suggested that social and personal problems reflected in high rates of male substance abuse and violent crimes concealed underlying male depression. Men showed their depression by acting out with anger, substance use, gambling, and overwork. All these visible actions covered "feelings of hopelessness, helplessness, and worthlessness, the hallmarks of depression" (p. 96). He accepted the notion that much depression in men is undiagnosed and untreated. Since men were socially conditioned to not be emotive and to not be emotionally introspective, he said men entered treatment later in the course of depression and in more pain than women (Kilmartin, 2005). He continued with treatment recommendations for clinicians who work with men. He suggested teaching men about how their sense of masculinity effected their process with depression. Attempts should be made to discourage rapid discontinuation of therapy, to expand the concept of masculinity to include a healthy display of emotions, and to provide an emotional vocabulary (Kilmartin, 2005).

Kendler, Gardner, and Prescott (2006) interviewed 2,935 men to gather data for the design of a comprehensive developmental model for men with major depression. They bundled 18 predictor variables into six major risk categories: childhood, early adolescence, late adolescence, adult, last year risk factors, and episode of major depression in the last year. Results showed genetic risk factors (one or both parents having experienced depression) was a strong predictor for early onset anxiety disorders, conduct disorders, increased exposure to difficult life experiences, and more episodes of stress during the last year. When men lost a parent at an early age, they were more likely to obtain lower educational achievement and have higher levels of substance misuse and stressful life events. Men with low self-esteem were at higher risk for depression. Results showed a direct path from substance use to a recent episode of depression. The authors compared these results to their prior study about women and depression and concluded that there were not enough statistically significant differences between results to separate male/female depression. Overall, results supported the etiology of major depression as basically the same for men and women. They suggested that answers about observed differences in men with depression could be due to how men dealt with depression.

The last study examined the relationship between negative life events, social support, and depression (Dalgard et al., 2006). Men and women reported similar rates of negative life events, but they identified different types of events as negative. Women were more influenced by events in their social network, illness, injury, or assault to themselves or persons who were important to them. Men also were influenced by events in their social network; but reported more problems with police, lost or stolen items,

marital separation, and unemployment. For both men and women negative life events had a strong association with depression and increased episodes of negative life events led to higher rates of depression. Results showed that decreased social support systems contributed to higher rates of depression in both men and women (Dalgard et al., 2006).

In this section researchers answered questions about the antecedents, evolution, and process of male depression. Men denied and obscured their depression. Men displayed alternate coping patterns and entries into treatment. Men tended to withdraw into their depression and not reach out for support. These differences contributed to hidden entrenched depression in men that was harder to diagnose and resistant to standard methods of interpersonal therapy. Researchers called for changes in standard depression screens that would reflect male symptoms of depression. Many studies made comparisons between men and women and how they dealt with depression. Some researchers called for gender specific studies with all male research samples to fill the gaps in knowledge about men and depression.

### **Explanation**

The prior examples of research have shown the evolution of the topic men and depression. The first works observed and documented a facet of depression that had not been separated out from the general body of knowledge about depression. Then studies were conducted to identify the parameters defining the concepts and related factors. Addis and Mahalik (2003) stated that the psychological, social, and biological processes underlying differences in men's depression were still not clear. Addis and Cohane (2005) wrote that men's mental health problems had not been a topic of major research. This

continued to present problems in men's lives because men under-utilized health care which ultimately effected men, their families, work places, and the community. These scholars argued that studies including both men and women and looking at differences on variables between sexes on health related topics was limited and created unhelpful stereotypes. They recommended, instead, that studies be designed to examine differences on variables between men. In explanatory essays, authors turned to theory to explain the meaning and causes associated with men and depression.

The most productive discourse on the why of male depression was found in men's studies literature. Men's studies grew out of women's studies (Addis & Cohane, 2005; Brooks, 2001; Courtenay, 2000). One important contribution women's studies made was to challenge standard DSM criteria for mental disorders (Brooks, 2001). Researchers began to acknowledge that the interplay between gender and social factors influenced how men and women cope with health concerns. Feminist studies showed that a woman's mental health needed to be understood within the wider context of her life (Brooks, 2001). Scholars of men's studies adapted this knowledge and applied it to men and their health. They originated the idea that masculinity was a malleable social construction and was subject to changes supported by gendered norms (Addis & Cohane, 2005). Masculinity was no longer understood as a single inflexible model, but rather composed of multiple competing models. Gender was conceptualized as a verb (Courtenay, 2000).

The masculine paradigm of hegemony developed in a parallel process along with feminist theory inquiry into power and social inequality. Connell and Messerschmidt (2005) wrote that after 20 years hegemonic masculinity had become an accepted social

theory. It had been observed across cultures and repeated over time. There were two fundamental features of hegemony. The first was that there were multiple masculinities influenced by social and cultural expectations. Throughout the life span, masculinity responded to external pressures and a man demonstrated different aspects of masculinity in different situations. The second feature was that hegemony included a ranking system. Within the hegemony of masculinity, different forms of masculinity were more or less powerful. Hegemonic masculinity was seen as “things done, not just a set of role expectations or an identity” (Connell & Messerschmidt, 2005). Few men really achieved idealized hegemony, but most men used it for a model of behavior that allowed them to position themselves in relation to other men and as superior to women. Men went to great lengths to avoid “feminine” behaviors like asking for help, expressing emotions, or seeking health care.

Courtenay’s (2000) paper was a seminal work in men’s studies. Courtenay began with numbers showing that men died 7 years earlier than women and had higher death rates in all 15 leading causes of death. These numbers were related to men’s insistence on maintaining a strong hegemonic sense of masculinity and avoiding behaviors associated with women. Each man pursued his own masculine identity within socially prescribed guidelines. For a man with high economic status masculinity could take the form of achievement in business or education. For a man with lower economic status masculinity could mean success in street fighting. The important thing was for each man to maintain male acceptance and supremacy within his own group. For men on all socio-economic levels this included engaging in riskier activities, enduring pain, and eschewing health

care. Seeking help was seen as a feminine and therefore not a masculine thing to do. Since women self-reported illnesses, including depression, more often than men and sought professional care more often, the rates of reported depression were most likely skewed.

Statistics did not accurately identify the rate of depression in men. Courtenay (2000) wrote “Denial of depression is one of the means men use to demonstrate masculinities and avoid assignment to lower-status positions relative to women and other men” (p. 1397). Depression included feelings of powerlessness, loss of control, and defeat. These feelings were not consistent with masculinity. The general association of depression with women made it hard for men to admit to feeling depressed. The “Doing of health is a form of doing gender” (p. 1388). Men and women did health differently. Men engaged in fewer preventative activities, more dangerous occupations, and were reluctant to seek help. Hegemonic masculinity promoted the ideal that men’s bodies were stronger and better able to endure pain. Social institutions like work, family, and health care reinforced expectations for men and notions of masculinity. Clinicians failed to diagnose two-thirds of depressed men (Courtenay, 2000). The combination of avoidance of things female, maintaining masculinity, and social factors had an important impact on men’s health and lifespan.

Brooks (2001) proposed that maintenance of masculinity threatened men’s mental health in ways that reached beyond the narrow confines of mental illness. Rigid compliance presented barriers to men’s best interests. He labeled this “the dark side of masculinity” (p. 287). Social constructs of masculinity taught men to use violence and

anger, which exposed them to more dangers. Men were socialized to see sex as a conquest which put them at risk for failing to develop intimacy and getting full support in relationships. Alcohol was socially condoned as a way for men to express masculinity and cope with stress. Maintaining masculinity also required men to take risks and to neglect personal needs. If men violated any of these pillars of masculinity they faced the anxiety of “Gender role strain” (p. 287). The tension created by perceived violations of masculinity reinforced returning to the defined role. Yet men who had a strong idealized image of masculinity were at higher risk for mental and physical illness.

Mahalik et al. (2003) defined different scripts of masculinity and how men who adopted them coped with health care issues. The “Strong-and-Silent Script” (p. 124) directed men to be stoic and in control of their feelings. It discouraged men from talking about feelings. Long term strict adherence to being strong and silent promoted not having words for emotions and a restricted emotional valence. Submerged emotions contributed to anxiety, anger, and depression. A second script, the “Tough-Guy Script” (p. 124) dictated men suppress feelings of vulnerability. This script promoted several risky behaviors. These men often used alcohol to mask feelings of vulnerability or engaged in dangerous behaviors to prove their manhood. The “Give-’em-Hell Script” (p. 125) endorsed violence and fighting to build character. Many organized male activities were centered on violence and the ability to endure pain including organized sports, the military, and fraternities. This script resulted in trouble with the law, cases of domestic violence, and greater psychological stress. The “Winner Script” (p. 126) told a man that he needed to be competitive and successful.

Some of the scripts contained positive characteristics. However, negative characteristics included an elevated level of stress associated with competition and often led to hypertension, heart disease, and early death. The authors suggested that each of the scripts valued masculine traits that have negative effects on men's help seeking behaviors. Adherence to these scripts made it very difficult for a man to engage in getting help which included relying on others, recognizing he had an emotional problem, or even admitting that he needed help (Mahalik et al., 2003). They concluded that internalized gender role scripts form additional barriers preventing men from getting health care.

Addis and Mahalik (2003) summarized two main gender-specific approaches to male role socialization. The first was masculinity ideology and was represented in the works of Courtenay (2000). It emerged from core beliefs and ideologies about what it meant to be a man. Masculinity grew out of and responded to pressures from social process. An individual's or a group's sense of masculinity changed with time. It also varied with the situation. The second approach to male socialization was gender role conflict. This was discussed by Brooks (2001). The supposition was that internalized masculine ideologies worked against an individual man's best interests. When this happened stress was created which resulted in physical acting out or cognitive, and emotional problems. For a better understanding of how these two models of male socialization contributed to men seeking health care they must be combined. The integration of both models explained that masculinity and help seeking were not fixed states but actually depended on "particular person-environment transactions" (Addis & Mahalik, 2003).

This merging of styles helped to explain how a stoic man of few words would seek help for a back injury sustained during a manly effort of hard labor but not seek help for depression. Addis and Mahalik (2003) formulated five questions men asked themselves before they got help for a life problem. Men needed a satisfactory response to these questions to help preserve their masculinity. Question number one asked if the problem was normal. Did other men have this problem; did they handle it themselves, would they get help with it? If the problem was normal it was safer to request help. If the problem was not normal it was riskier to admit to having the problem and to ask for help. Depression, an emotional problem was not supposed to be normal for men and therefore made it more difficult for a man to acknowledge and ask for help. What was normal was influenced by popular culture. If a male celebrity or sports figure admitted to episodes of depression, other men were more able to share their feelings.

The second question asked if “the problem is a central part of me” (Addis & Mahalik, 2003, p. 10). Men decided how threatening the problem was to their masculine identity. Many men thought getting help for depression was a threat to their self-esteem and a challenge to their sense of being in control. A third issue for men was if they would be able to pay back someone else for the help they got. They wanted to feel they could reciprocate by helping someone later. In the aftermath of a storm men liked to help each other with property repairs and felt comfortable accepting help from other men. With a problem like depression men saw no way for them to help anyone else and this made it more difficult for them to accept help. Another question men asked was what other men will think of me if I get help? If the men in his family, work group or among his friends

expressed consistent messages about how men needed to be physically and emotionally strong, it was more difficult for a man to seek help. Last, a man asked himself what he could lose if he got help. The belief that he was giving his control to another person was a big threat to his masculinity.

Finally, Phillips (2006) summarized male developmental theories under two main categories. The first category included psychodynamic theories and described masculinity as a “fixed essence, defined by innate biology, psychology, or by theology” (p. 421), which was influenced by outside events. These traits were fixed early in life when a young boy experienced individualization from his mother. He was encouraged to act independently, to be strong, and to not rely on connections. Most important he learned to not be like a woman (Phillips, 2006). This category included hegemonic masculinity and gender role strain. The second category included social theories and described masculinity as multidimensional and changing. Sex was the biological unchangeable trait, while gender was seen as socially constructed and changeable. The author concluded that the more traditional theories about masculinity have not served men and their health care needs well. She suggested a post-modern orientation which helped to deconstruct fixed notions of masculinity and encouraged critical thinking about how assumptions about gender and behavior influenced health consequences. The new model presented more opportunity for improvement in men’s mental health (Phillips, 2006).

The literature review has provided an overview of knowledge about men and depression as a separate facet of depression. To date researchers have looked at differences between men and women, factors contributing to male depression, male

defenses against depression, and the social impact on men with depression. They have presented strong arguments about why studies should be conducted on men as a separate population. Research has not approached the topic of men and depression from a nursing or a unitary perspective. It has not asked how all of the information would get integrated into a meaningful holistic understanding of men and depression.

### **Unitary Appreciative Inquiry**

Rogers left nursing scholars with the challenge of designing ways to incorporate knowledge of unitary human beings and pattern manifestations into nursing research. Unitary appreciative inquiry (UAI) was developed as a research method for “discovering and generating unitary knowledge” (Cowling, 2004, p. 202). Unitary knowledge uses knowledge that is situated in the view that each person is a unique and irreducible energy field which is integral with his/her unique and irreducible environmental energy field. This expansive view of the human experience seeks to include empirical information, both mental and physical, and the deeper metaphysical aspects of life. The goal is to produce a synoptic understanding of the human condition that “avoids the neglect of important facets of human life that are not fully accounted for when human phenomena are ‘clinicalized’ with an over-emphasis on diagnostic representations” (Cowling, 2004, p. 202). UAI promotes a practice that emphasizes human field patterning instead of disease or diagnosis (Cowling & Repede, 2010). The ideal is for knowledge generated with UAI to be used for the betterment of human beings. With that ideal in mind UAI has developed into a research and practice tool, praxis. In the past 20 years UAI has made “contributions to an evolving nursing science of wholeness,” provided a research method

to study human wholeness, and offered “a wholeness-focused path to nursing care” (Cowling & Repede, 2010, p. 4).

UAI is a complex mid-level theory (Repede, 2007) established with a distinctive orientation, process, and approach (Cowling, 2001; Talley, Rushing, & Gee, 2005). UAI collects information using multiple ways of knowing through experiences, perceptions, and expressions, to understand the underlying life pattern of human conditions. The orientation of UAI is the wholeness and uniqueness manifested as a single pattern, based on meaningful interpretation for all participants (Cowling, 2001). Agreement on pattern interpretation between researcher and participants gives the method an internal reliability.

The UAI process has four essential aspects; appreciative knowing, and participatory, synoptic, and transformative features. Appreciative knowing posits “that human life is a miracle that never can be comprehended fully” (Cowling, 2001). This starting point lets the researcher look beyond traditional data and develop a deeper understanding and respect for variations in life patterns. The appreciative aspect promotes affirmation rather than exclusion of multiple life patterns. Within appreciative knowing is the conscious intent that the researcher and participants are co-researchers. They are equals; each brings unique contributions to the process. The participants are the experts on their experiences, perceptions, and expressions. Parties openly share in the voluntary process of knowledge creation. The result of such inquiries creates unpredictable results. The post-modern participatory nature of UAI allows for knowing changes in patterning and empowering participants.

The synoptic process is used as an alternative to strict analysis of data. Analysis in research is used to dissect information, isolate factors, seek out causative factors and uncover correlations. In contrast, synopsis is bringing together and viewing the entire pattern manifestation of the unique human energy field, including intervening factors that other forms of data analysis attempt to control. Synopsis accepts this information and considers it for inclusion in the human story. Information that might not have been linked together can take on underlying integrated meaning (Cowling & Repede, 2010). This new way of looking at information as a manifestation of human patterning provides deep insight into phenomena. The synoptic process is used to tell a personal story. As an outcome of UAI, the personal story is used as a reference point for considering ways to achieve betterment of human beings in particular and general ways (Cowling, 2001). Unique and particular themes are beneficial to the participant. The general themes contribute to the larger body of knowledge and are applied to other people presenting with similar pattern manifestations, in this case, men with depression.

UAI engenders the betterment of the human condition through transformation. This is a conscious and active process in which the participants willingly engage in change. UAI is a method of research *with* people, not *about* people (Cowling, 2004). It allows that people have a right to contribute to knowledge development about their lives. They are given the results of the research project for their own use. The transformative process empowers people to examine their life patterning manifestations and engage in desired change.

The approach of UAI starts with a purposeful exploration of phenomenon with a unitary perspective (Cowling, 2001). The emphasis is on appreciating the wholeness and uniqueness of irreducible energy fields, and “constructing a unitary pattern profile from the multiplicity of pattern manifestations, information, and knowledge emerging from the inquiry process” (Talley et al., 2005, p. 31).

The currency of UAI is the study of patterning. Pattern, patterning, and manifestation of pattern were established by Rogers in the science of unitary human beings as “a distinguishing characteristic of an energy field perceived as a single wave” (Rogers, 1992, p. 30). Phillips (1997) cautions scholars not to confuse Rogers’s single wave with a linear wave as described in physics. Rogers’s energy wave is pandimensional. Energy fields are observable through manifestations of patterning of the dynamic and shifting interchange between humans and their environment. “Pattering of the living system subsumes within it both structure and function” (Rogers, 1970, p. 62). In the science of unitary human beings structure is a slow process of long duration. Function is a quick process of short duration. Pattern is deliberately an abstract concept, yet unique to an individual, and reflects the identity of that individual energy field. Pattern along with organization are unifying concepts, “They are observable properties of all there is” (Rogers, 1970, p. 62).

In the midst of all the energy exchange and re-patterning which constantly occurs between man and his environment, man retains the ability to exist “as an organized whole possessing his own identity” (Rogers, 1970, p. 63). The human energy field is integral with its environmental energy field and together they evolve with one another (Rogers,

1986). Change is continuous. Pattern is not visible but the manifestations of pattern, patterning, is visible. Manifestations of pattern are “observable events in the real world” (Rogers, 1986, p. 6), and include physical, mental, emotional, spiritual, and metaphysical events. Creation of unitary knowledge through UAI views these events as the manifestation of a single pattern and through the lens of synoptic reasoning gains new understanding. Manifestation of patterning becomes visible through individual perceptions, experiences, and expressions.

Alligood and Fawcett (2004) presented a consolidated explanation of Roger's concept of pattern:

Rogers consistently identified *patterning* as the visible manifestation of pattern in the real world. *Pattern*, as used by Rogers, is an abstraction and a noun. Therefore, pattern is an entity. In contrast, *patterning*, as used by Rogers, is the dynamic or active process of the life of the human being. Manifestations of patterning are visible or otherwise accessible to the senses [italics in original] (Alligood & Fawcett, 2004, p. 11)

Important pillars of the concept included that organization and patterning in living systems are observable. Patterning is a dynamic process that includes constant revision and innovation, pattern is abstract and patterning is observable, and change includes increasing diversity. Alligood and Fawcett (2004) concluded that for the nurse in practice patterning, the verb is a more useful term than pattern. This supports the active engagement of nurses as they “encounter people in the process (patterning) of their lives” (p. 12).

UAI welcomes the inclusion of multiple ways of knowing in gathering pattern information. Traditional forms of information about physical, mental, and emotional status can be used. Less traditional forms of information including music, journaling, dance, poetry, and imaging can contribute to more inclusive pattern formation (Cowling, 2000, 2004). UAI then generates four types of knowing (Cowling, 2004; Talley et al., 2005). These types of knowing are consistent with the participatory worldview and are borrowed from participatory and cooperative inquiry processes (Heron & Reason, 2001). The first is experiential knowing which is acquired through direct personal contact. It involves empathy, shared experiences, and deep understanding. Presentational knowing is built on experiential knowing and becomes apparent through a creative work such as writing, music, or poetry. Propositional knowing includes concepts, ideas, and theories which are the product of the synoptic process. It generates new knowledge that is “unique to the phenomena of concern and/or are applicable in more global situations” (Talley et al., 2005). Practical knowing which emerges from UAI provides knowledge that is useful in developing interventions for the betterment of human beings, and personal growth.

### **Conclusion**

For multiple reasons, I have chosen Rogers's science of unitary human beings and Cowling's unitary appreciative inquiry for the foundations of my research into men and depression. These are both complex nursing theories and take some additional effort to understand. I wanted theories that were epistemologically and ontologically cemented in nursing. I believe for nursing to gain respect as a distinct profession, it needs its own body of knowledge. SUHB and UAI fit well within the framework of my chosen area of

psychiatric nursing. They offer a dynamic supportive structure that provides opportunities for personal learning and change. These theories are all inclusive.

After 30 years in nursing, I feel that other models of human/nursing/medical interactions did not represent the gestalt of nursing. All the research about brain chemistry, neurotransmitters, and diagnostic criteria failed to capture or explain my clinical observations. Traditional theories fell short of describing, explaining, or predicting the unitary nature of human experiences I encountered. They did not encompass the range of the irreducible field pattern manifestation presented when I evaluated a post-operative patient for failure to progress and learned the true concern was not physical pain but loss of the desire to live due to concern about a beloved grandchild. Conscribed theories left huge gaps in clinical knowledge as I evaluated a depressed man in the emergency room who arrived with the instruments he planned to use to end his life. Nor did it prepare me for the depressed man I saw as an outpatient who arrived for his appointment on time, impeccably groomed and shook hands politely, but as soon as the office door closed broke down and sobbed to the point of being speechless.

SUHB and UAI create an open democratic forum for nurse/patient interactions with the establishment of the equalitarian role of participant/researcher. I have been humbled by my privileged experience as a psychiatric nurse and have learned so much from my patients. UAI celebrates the human being in human research. And lastly is the transformational aspect of UAI. I have experienced that transformational exchange with patients when I knew that we had, in a moment, evidenced change. I never had words for it; I just told new nurses they would know it when it happened. The topic of men and

depression still troubles me. Almost monthly I hear of another case of suffering or suicide. I believe men carry a disproportional burden of suffering, decreased quality of life, and increased odds of suicide. For those reasons, this research project used UAI to appreciate pattern manifestations from men in whom depression was a prominent feature of living.

## **CHAPTER III**

### **METHODOLOGY**

#### **Introduction**

This chapter presents a method for studying life patterning of men with depression. Life patterning is a concept derived by W. R. Cowling (personal communication, February 17, 2010) from the science of unitary human beings and the more abstract concept of human field patterning. The conceptual meaning of life patterning is the representation of human field patterning as experienced, perceived, and expressed by individuals, or groups of individuals W. R. Cowling (personal communication, February 17, 2010). For the purposes of this study, it provides an inclusive concept for interpreting a holistic image of what occurs when a man has depression. Life patterning embraces a man's experiences, perceptions, and expressions viewed through a synoptic lens as manifestations or reflections of human field patterning derived from daily living with depression including the existential meanings attached to life events. Each participant was invited to share his story about depression, information about deciding to seek help, and what coping methods were useful. The questions that formed the framework of this inquiry were: What is the individual life patterning of men self-identified as depressed as experienced, perceived, and expressed? What is the mutual life patterning of men self-identified as depressed as experienced, perceived, and expressed? What are the life patterning features of men seeking help for their depression?

The insights uncovered by men during personal interviews were used to develop a unitary holistic understanding of men with depression. Included in this chapter are descriptions of the conceptual framework and proposed study design which includes the study sample, data collection method, data synopsis method, and method for evaluating legitimacy and credibility.

### **Conceptual Framework**

Unitary Appreciative Participatory Inquiry (UAPI; Cowling, 2001, 2007) is the method used in this qualitative, descriptive, exploratory study. Many elements of UAPI research including but not limited to methods for participant selection, data collection, measures for validity and reliability, and the Institutional Review Board process, are consistent with other established qualitative research methods. UAPI also shares postpositivist perspectives that include “multiple methods as a way of capturing as much of reality as possible” and an understanding that “reality can never be fully apprehended, only approximated” (Denzin & Lincoln, 2005, p. 11). UAPI values and embraces many of the tenets from participatory action research, particularly cooperative inquiry involving working with people on identified issues in their daily lives to effect change (Reason & Bradbury, 2001). Both research methods trust participants to be co-researchers and experts on their own experience. UAPI embraces the understanding that people will participate in creating data and then choose to use the results to improve their own condition (Heron & Reason, 2001).

Several features set UAPI apart from other forms of research. It grew from values held by the nursing discipline. Nurses are charged with helping the whole human being

obtain his or her highest individual and most complete and holistic quality of life. A foundation of nursing practice is nursing diagnosis, a cooperative process, which starts with the nurse and client identifying a problem, articulating supporting evidence, and identifying factors related to the problem. Then with the clients help, long and short term measurable goals are identified. Together clients and nurses work towards solutions. Nurses want to know what the problem is, how it impacts a person's life, and what the person thinks would be a reasonable solution. Nursing is a collaborative practice. UAPI welcomes nurse-client collaboration within participatory research. UAPI involves praxis, the integration of nursing theory, person centered research, and nursing practice for the betterment of human beings.

UAPI seeks to develop a holistic unitary understanding of the human condition. UAPI research strives to be inclusive, using multiple sources of knowledge and observing emerging patterning. In this study, manifestations of patterning were sought from the perceptions, experiences, and expressions as discovered by co-researchers through shared reflection and co-creation. Human experiences, perceptions, and expressions have both internal and external aspects. Various aspects of the human experience of depression that are inclusive of life patterning included felt sensations, seeking meaning from, and reactions to depression. Examples of information and observations collected included personal reports of sadness, beliefs, and individual thought processes. Consistent with UAPI results were considered and contextualized through a synoptic lens which brought them together emphasizing interrelatedness and wholeness (Cowling & Repede, 2009)

UAPI embraces and understands that unitary human beings are constantly participating in their own patterning; this is the basic life process. Additionally, unitary science and the participatory world view support the idea that unitary human beings have the ability to participate knowingly in that patterning (Cowling, 2001). The knowing participation can be intentional and focused. In this manner people are capable of making choices and using knowledge for transformative change. The actual research project provided each participant an opportunity to develop insight and understanding of the wholeness of patterning encompassing his life. UAPI was developed to bring together the theory and practice of nursing in praxis to improve human wellbeing (Cowling, 2004). Data is interpreted, through a nursing lens using synopsis (Cowling & Repede, 2009).

### **Study Design**

#### **Researcher's Preparation**

Original interview questions were developed with the intention of eliciting in-depth responses about the wholeness of the experience of respondents and their depression (see Appendix A). Before my first interview, I did one pilot interview with a man. I began each interview by asking the man if he wanted to simply start telling his story or if he wanted me to ask a question. Some chose to start with a question. The questions were also referred to at times during the interview to generate thoughtful conversation. In line with qualitative research, the design remained emergent. Questions grew out of each interview. They were reformulated and personalized (Gliner & Morgan, 2000). It was more productive for the men to select topics that were meaningful for them to talk about.

I prepared a brief demographic questionnaire. The information gained by this questionnaire was helpful in producing background information. The demographic information summaries provided additional context to each story. It provided data that might not have emerged during the interview like marital status, number of people in the home and years of education all of which helped create a more complete understanding of these men and their life patterns.

### **Population Sampling**

In qualitative research the sample size is not decided before the research begins. The sample size is established during the study by the need to answer the research questions. The number of participants necessary varies based on several factors. They are the quality of data collected and the depth and scope of the research questions (Polit & Beck, 2004). Data collection is continued as long as information is generated that will contribute to a new understanding of the topic. Participants are recruited and interviewed until data saturation occurs. Saturation is the point when no new information is emerging from additional interviews (Glaser & Strauss, 2006; Polit & Beck, 2004). At the saturation point data becomes repetitious. This redundancy means that saturation has been reached and “signifies completion of data collection” (Speziale & Carpenter, 2007, p. 460). Consistent with Denzin and Lincoln (2005), the goal of this research was to include enough participants to “capture the individual’s point of view” and at the same time “secure rich descriptions” (p. 12) about a wider population of men and depression. In qualitative studies a small sample allows access to valuable data and provides avenues for gathering in-depth information. Also one researcher may participate in the entire data

gathering process. The desired sample size for this study was originally between 10 to 12 men. The actual sample size was six men. This occurred due to many factors including the time constraint for the research project and the location for the research in a small city. The actual sample of six men produced rich and honest information about men and depression. There were many areas of saturation and redundancy.

Volunteers were screened to be included in a convenience sample with the intent of assembling a sample that was most representative of the larger population of men with a personal history of depression. This researcher directed sample selection helped to generate results that would apply to the larger population of depressed men. Participants were solicited from the general population by advertising in newspapers and posting flyers in the community. The sample was composed of participants who self-identified as having personal experience being depressed. They all expressed an interest in sharing their individual histories and acting as co-researchers contributing to a larger body of information about men and depression. This selection process produced participants who were different from many men experiencing “intense and chronic” depression (Warren, 1983, p. 154) classified in the DSM or acute depression. Inclusion criteria (see Table 1) were confirmed by participant’s self-identification and self-report.

Participants needed adequate communication skills in order to share their story. I am only fluent in English and needed be able to communicate with the participants without the use of an interpreter. While including participants communicating through interpreters can provide useful information, my experience of working with the Deaf community and using interpreters has convinced me that words and meanings are often

changed and substitutions used. Participant communication skills were assessed during the initial telephone conversation.

**Table 1**

**Inclusion and Exclusion Criteria for Men and Depression Study**

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Ability to speak, read, and comprehend English	Co-occurring mental or physical illness
Self-identify between ages of 21-60	Primary substance abuse diagnosis
Self-identify personal experience of depression During the last 5 years	Recent (past year) death of family member or significant other
Transportation to and from interview	
The desire to share his story	

The age requirement was included for two reasons. The first was to avoid any possible inclusion of young men who were not of legal age to give consent for participation in a research study. The second was to include males who were of post-secondary education age and were facing life challenges as adults. These age parameters increased the chances of identifying participants who were in their healthiest and most productive years, and generally free from other health concerns. The age criterion was easily validated. Men simply answered the direct question about being over 21 years old. Also at the first interview and during a face to face encounter with the men, it was clear that they complied with the age criteria.

The time constraint for having experienced depression within the last five years was selected for several reasons. With the rapid changes in health care and information technology a five year limit would bring more standardization to what information and options were available to men. Also a limit of depression in the past year might prove too vulnerable a time period for participants. The goal was not to interview acutely depressed men who have not had adequate time to process their feelings. Participants self-identified as having depression. They may or may not necessarily have been diagnosed by a health professional. This acceptance of participants naming their depression reduced the tendency to define and limit their experience. It also acknowledged a basic premise of UAPI that each participant was the primary expert on his experience. In order to participate in the study participants needed be able to provide their own transportation to and from the interviews. They needed to have a willingness to share an overview of their experience of depression. Their own willingness to participate in the project facilitated the research process and injected validity into the results. By setting guidelines the group did become more homogeneous. The commonalities built into inclusion criteria strengthened results for this sample of men. Research with men and depression at other ages and developmental stages could prove fruitful in later studies.

The rationale for exclusion criteria follows (see Table 1). Men with co-occurring mental illness and physical illnesses were excluded in order to concentrate on a more pure male depression. While it is true that depression often follows a diagnosis of schizophrenia, diabetes, or cardiac disease, the focus of this study was primary

depression in men. Likewise substance abuse and active grief fall outside the range of primary depression.

Men were recruited to participate in a “Research Study associated with the University of North Carolina, Greensboro.” They were invited to “Share Your Story” about “Men and Depression.” I chose to use the word depression aware of the possibility that men often use other words for depression. They often refer to their depression as stress. I preferred men to respond to the word depression. I felt that would leave no doubt that the research was focusing on men with depression. Using the word depression in recruitment materials would reduce ambiguity and provide more reliable results. During the actual interviews men did call depression by different names. This initial word choice may have excluded men who use different labels for depression. Several men in my study suggested I change the word from depression to stress. They said I would have men beating the door down.

A paid recruitment advertisement was placed in the local newspaper (see Appendix B). The ad ran 20 times in the local paper over two months. It was the size of a business card ad and was placed in various sections of the paper on random days. Recruitment flyers (see Appendix C) inviting participation in the research project were distributed in places frequented by men with diverse backgrounds. The flyers were posted on community bulletin boards at several restaurants, the YMCA, several branches of the library, and a food kitchen.

## **Interview Format**

Qualitative research is “a profoundly *human* endeavor” (Emden & Sandelowski, 1998) that includes the sensitivity and values of all participants. Polit and Beck (2004) identified personal interviews as a highly respected method of data collection. Face-to-face interactions using reflective dialogue yield large amounts of quality data and respondents tend to be more willing to disclose information. Richards (2005) endorsed the interview process for human research saying this method had the potential for revealing unexpected insights. Emden and Sandelowski (1999) wrote that qualitative research includes a “criterion of uncertainty” (p. 6) that actually strengthens the study. In qualitative studies, the quest to find full expression can benefit as “uncertainty can be turned to advantage, and novel avenues of thought forged” (Emden & Sandelowski, 1999, p. 5). Data for this project was collected during face to face interviews which offered the opportunity for contemplative discourse between participants. The uncertainty included in the unstructured design fostered emersion of new information about men and depression.

## **Location**

The interviews were conducted in private office space donated by the Women’ Resource Center. The building is an old Victorian farm house located in a public park near the downtown. There are no other buildings in the park. It had interview spaces on the first and second floors and was wheelchair accessible. In spite of the facility name; men partake of services provided by the agency. The Women’s Resource Center provides some minimal emergency services to men. There are daily 12-Step meetings in the

building which men attend. There are usually other men around providing maintenance services. The offices were private and quiet. They were comfortably furnished with desks and overstuffed chairs. Research participants were greeted by a center volunteer receptionist well versed in confidentiality issues. The neutral location provided privacy and anonymity to participants. All of them men said they were entirely comfortable coming into the Women's Resource Center.

### **Data Collection**

Men who responded to posters or advertisements about the project with an expressed interest of participating in the research project initiated the process by leaving their contact information at an email site ([m\\_kauf@uncg.edu](mailto:m_kauf@uncg.edu)), or with one of two telephone message systems. I called them to arrange a suitable time for a telephone screening and information session. This often occurred during the initial telephone call. These preliminary conversations served as a brief introduction to the project. The time was used to begin establishing a working rapport between co-researchers. This was actually the first step in data collection. I did follow the list of pre-screening questions (see Appendix D) closely to identify whether a man met the criteria for inclusion and had the time to commit to the project. We established a time for the initial interview. Participants were encouraged to use the intervening time before the appointment to think about their experience of depression and how best they might tell their story. They were encouraged to share their experience through writing, pictures, or art work they would like to bring to the interview session. These additional sources of information could be anything that helped them relate their personal experience of depression. Only one man

brought in outside information. He brought in a prior evaluation from a psychologist, numerous letters, newspaper clippings, and family pictures. He used items to validate his story and to establish himself as a good person who was mentally stable.

At the appointment and before the interview began participants were asked to sign an informed consent form to participate in the research process (see Appendix E).

Participants were provided with information about their right to withdraw at any time. They were asked to complete a brief demographic survey (see Appendix F). Two digital audio recorders were used to record each session to insure accuracy, to allow for ambient noises, and to provide backup in case of equipment failure. The co researchers both had paper and pencils during the interview to record brief thoughts. At the end of the session, participants were invited to set up a follow up appointment.

In the interim between the appointments I contacted each man by email and offered to send him a typed copy of the transcript from the first interview. If I did not have the email address, I contacted him by phone or offered the transcript at the beginning of the second meeting.

During the second interview, each man was questioned about his response to the first interview. He was asked what it had been like to talk about his depression. He was encouraged to share any additional information that he wanted to share as a result of internal processing he may have done between sessions. Each participant was given a copy of his individual patterning profile as conceived and written by me. He was asked to read the patterning profile transcript for accuracy. He was asked how well the personal profile portrayed his experience. My goal was for him to acknowledge the document was

a true representation of the life patterning of his depression. He was encouraged to comment on the information and make additions or corrections about how best to improve the profile of his depression to help me understand the impact depression had on his life. Participants were informed that as a larger part of the research project their stories would be included with other men's stories to create a more comprehensive understanding of the male experience of depression. He was asked for suggestions that could improve the interview process. This final meeting offered the chance for closure between the researcher and the participant. It formally ended the man's commitment to the research process.

Data organization was plotted on a checklist (see Appendix G). This tracked stages in the research process such as initial contact, informed consent signed, appointment times, etc. Each participant has been referred to by his chosen pseudonym. This name protected his privacy and has remained with him throughout the research project. Project notes were generated about each encounter and contained the PI's observations and thoughts. Notes were entered about any problems encountered during the interview and recommendations for changes with future interviews. Personal folders included the initial transcription interview and follow up interview. It also contained a copy of project notes, the demographic questionnaire, the consent form, and the patterning profile. A copy of the additional material provided by one participant from his own file was included in his folder.

The goal of collecting and organizing qualitative data is to create records that retain complexity and context (Richards, 2005). Qualitative research must provide a rich

and thick recount of the data by detailed descriptions (Polit & Beck, 2010). The bulk of the data was narrative self-reported stories collected during personal interviews. As soon as possible after the interview a professional transcriber entered the data into a computer word file. Data was protected during computer processing with frequent backups. All transcribed data was saved on two storage units separate from the main computer; either flash drives or CDs that are password protected. All records have been stored in locked files in my home office.

Richards (2005) states that all data must be cleansed and reduced to a meaningful and manageable information fund; but that with qualitative research it is desirable to do this late in the research. The transcription was edited throughout the research process in order to remove some narrative that was extraneous and not focused on the male experience of depression. Most of the interview was retained intact far into the research process and until it was apparent that it offered no additional information. This more complete data base helped to generate a deeper more contextual understanding of the material. The audio recordings and the data storage units will be retained until the end of the dissertation process. This will make them available for repeated reviews. Multiple reviews can reveal additional information and contextual nuances that enrich the final research results.

Each interview was studied by reviewing both the typed transcript and the audio recording. The one participant who provided non-verbal sources of information, newspaper clippings and a prior psychological evaluation was encouraged to talk about how these contributed to his understanding of depression. The information was included

in the transcript as his description and instilled additional meaning that supported his personal way of knowing depression. During the first review, attention was focused on emerging inclusive themes about what living with depression personally meant for each participant. What was the unique patterning profile related through his narrative? Through content synopsis derived from the transcripts, the information will be used to create an individualized pattern profile.

After all of the individual interviews were completed to provide a rich description of patterning in individual men with depression, the data was re-examined. The focus of the second review was on retrieving some universal themes that appeared across the total collection of patterning profiles that may be generalizable to the larger population of men with depression.

### **Data Synopsis**

Life patterning of men with depression is a UAPI qualitative research study to describe and explore the topic through the lens of wholeness. In UAPI data is generated through mutual dialogue, reflection, and aesthetic expression (Cowling & Repede, 2010). This produces process oriented and participatory, unitary knowledge that is generated by a continual and vigilant focus on the wholeness and patterning of the individual.

Based on the unitary participatory inquiry model of research, personal interviews with engaged dialogue were used to generate the data through narrative descriptions of what life patterning was like for each depressed man. Through the process of volunteering, men who participated in this project tacitly demonstrated a desire to share their story. Individual interviews provided a secure opportunity for participants to share

their thoughts and feelings. This research design did produce a volume of self-reported data.

The goal of all research is to generate new knowledge about the topic of study. UAI accomplishes this through synopsis, a process bringing together and unifying disparate data collected from multiple pathways. It seeks to consider the value of all information gathered by co-researchers and absorb it integrally to appreciate the patterning of the whole. Co-researchers share the assumption that some knowledge is accessible with the conscious mind through apperception, recognition, evaluation, and volitional acts; and some knowledge occurs at less accessible levels like intuition, instinct, and dreams (Jung, 1976). By the process of data synopsis, which seeks to include these additional sources of knowledge; research guided by UAI hopes to garner an extensive understanding of the patterning and wholeness of men with depression. In this study all aspects of the human experience of men and depression obtained during data collection were intentionally and equally regarded. The UAI synoptic method offered a possibility “to sense an emerging pattern that reflects the wholeness and uniqueness” (Cowling & Repede, 2010) shared by a group of men with depression.

Synopsis is much more than reviewing and reporting on the information obtained from interviews. Essential to synopsis is the search for “the connections, themes, commonalities, and relationships among the data” (Cowling, 2010, p. 74). It is “working up from the data” (Richards, 2005, p. 67). The process begins with the awareness that a researcher does not know what will be learned from the data; but ideas will emerge from the data. Information obtained from each interview was often incorporated into and

further explored in the next interview. The ongoing integration of ideas continued through successive interviews. Each interview was a learning process for the researcher. As ideas and themes emerged they were compared across interviews. Common threads and topics emphasized during interviews begin to expand understanding and nurture interpretations. Richards (2005) instructed one to question why a statement was interesting, to question how it related to the topic, and to explore what new insight it contributed. The objective was to broaden consideration of interesting ideas and explore how they enhanced a deeper, richer, thicker reflection of the patterning of the wholeness of men and depression.

Intuition played an important part in creating meaning from the data. Collective data was allowed to ferment in the nurturing framework of appreciating human wholeness. The chemistry that occurred from bringing together data while respecting multiple ways of knowing from a representative sample of men emerged through patterning of the whole and illuminated new insights about men and depression.

### **Human Subject Protection**

Institutional Review Board approval was granted for this research project from the University of North Carolina, Greensboro to ensure compliance with human study guidelines (see Appendix H). The board determined that the risks for participants in this study were minimal. Potential participants were screened for appropriateness and willingness to take part in the study. They were given information about the goals of the study and their time commitment. During the first appointment and before the interview began each man was given a typed consent form to read. He was encouraged to ask

questions about the process. He was also informed that he could withdraw, without penalty, at any time from the project. He then signed the consent form indicating his desire for voluntary participation. He was given a copy of the consent form. There was a list prepared of local resources providing mental health in the event any participant requested a referral or experienced distress from the research process (see Appendix I). In fact all of the participants were already involved in some form of treatment and or were involved with an insurance based system. All information collected for this project was secured in a locked file cabinet in the principal investigator's home office. Computer files were processed and saved on a password protected computer. In order to preserve the confidentiality of each participant, he was identified by a pseudonym that he chose. All information about a participant was stored under that pseudonym.

### **Credibility and Legitimacy**

Working within the UAPI framework, I did not have an expectation to uncover a single or absolute truth about men and depression. Inherent in UAPI is the belief that each individual experiences life uniquely. There is no expectation that results can be replicated. The notion was to contribute to the body of existing knowledge about men with depression. The goal was to produce valid conclusions that accurately reflected life patterning of men with depression and contributed to the betterment of this population.

The standard measures of reliability used to evaluate research are not consistent with the unitary transformative framework. Denzin and Lincoln (2005) and Speziale and Carpenter (2007) wrote that in qualitative research, measures of reliability and validity have been replaced by the concepts of credibility, dependability, confirmability, and

transferability. Credibility is established through “activities that increase the probability that credible findings will be produced” (Speziale & Carpenter, 2007, p. 49). One way to create credible data was to engage with the subjects for a prolonged time. Designed into this project the co-researchers engaged in lengthy personal interviews with participant. The total time for both interviews was at least three hours. Speziale and Carpenter (2007) also recommend offering subjects the opportunity to review findings to determine content accuracy. All participants were offered the opportunity to read a typed transcript of the first interview. They were also given a typed copy of their individual pattern profiles. Participants were encouraged to review and modify typed documents.

Dependability measures the trustworthiness of qualitative research. It is established when the data is found to be credible. As participants in this study reviewed and amended their patterning profiles, the data was established as a more dependable source of knowledge about life patterning for these men and their depression. Conformability was accomplished when researchers “leave an audit trail which is the recording of activities over time” (Speziale & Carpenter, 2007, p. 49). As engagement with each man advanced a list of audio, computer, and typed documents was established. For each man there are the initial pre-screening form, the signed informed consent, the digital recording of the interview, the typed transcript of the interview, the individual patterning profile, and hand written notes.

Transferability is the fourth concept for evaluating qualitative research. Knowledge emerged from this project in two forms. First, many of the topics that men talked about supported previous studies. That consensus strengthened both prior studies

and this one. Second, new themes about men and depression became evident in the first interview and were repeated in subsequent interviews. This redundancy established themes transferable across the study population. The common results from this study added to prior studies did illuminate the topic of patterning in men with depression and provide information that was meaningful to a larger population of men with depression.

Cowling and Repede (2010) identified four criteria when evaluating UAPI research. The first was the quality of the data and how well it represents a full and comprehensive “picture of wholeness as expressed in life patterning” (p. 75). In this study a contribution to knowledge about men and depression was achieved by actively engaging participants in the research process, including multiple sources of data collection, and integrating layers of information through the synoptic process. Second was the investigator bias in terms of how well prepared and how sensitive she is to appreciating patterning and human wholeness. I continue to learn about the UAPI method of research; however specifically chose it because of the holistic unitary focus, the high value it placed on all forms of information, and importance of working with participants to include their voices. It is a very personal and relational type of research. The research is conducted with people and not on people.

Third was the quality of the research design and how well it was able to capture and generate knowledge about “life patterning in human wholeness” (p. 75). My underlying belief was that depression in men must be studied as a unitary phenomenon and that previous research has failed to capture what depression means in the context of the wholeness of men’s lives. An understanding of the wholeness of men and depression

must be examined from a unitary view that includes understanding life patterning, a concept not contained within mental or physical boundaries. Fourth was the usefulness and transferability of the research in promoting healthful changes in life patterning. In an effort to capture the experiences, perceptions, and expressions of depression in the wholeness of life patterning in men, this research project appreciated data generated across a spectrum of male experiences of depression. In UAPI “a critical feature of synopsis was to search for connections, themes, commonalities, and relationship among data” (Cowling & Repede, 2010, p. 74). The individual contributions collected in this study viewed through synopsis created meaningful associations that were valid that could benefit a larger population of men with depression. Participants gained personal knowledge about their own life pattern. The men felt good about their participation. Some said it was a therapeutic experience. They also felt empowered by sharing their story and the belief that their effort could help other men. This is consistent with the ideal of transferability and transformation.

## **CHAPTER IV**

### **RESULTS**

#### **Presentation of Findings**

This research study was designed to explore the life patterning of men experiencing depression through a unitary lens. Participants in this study were men who have lived with depression who were invited to share their stories. The study employed a unitary appreciative participatory inquiry (UAPI) framework (Cowling, 2001, 2004) to evoke each man's memories and feelings on how depression impacted his life. The research questions for this study were: What is the individual life patterning of men self-identified as depressed as experienced, perceived, and expressed? What is the mutual life patterning of men self-identified as depressed as experienced, perceived, and expressed? What are the life patterning features of men seeking help for their depression?

#### **Sample**

The sample consisted of six men between the ages of 21 and 59 years old who responded to newspaper and flyer advertisements of the study (see Table 2). All participants resided in a rural community and self-identified as living with a history of depression. One man identified himself as Latino/white. He was born in Colombia and was a naturalized American Citizen. He was bilingual and fluent in English and Spanish. The other five participants were white males. Three men were high school graduates; one

had a bachelor's degree, and two had graduate education. Income ranged from less than \$10,000 to over \$75,000 per year.

**Table 2**  
**Demographic Data**

Variable	Participant Number					
	1	2	3	4	5	6
Age	>40	56	56	>50	46	21
Ethnicity	White/ Latino	White	White	White	White	White
Marital Status	17	18 years	>25 years	Divorced	>15 years	Never
Education	Some College	Some College	> 4 years College	> 4 years College	4 Year College	High School
Income	<\$25,000	>\$75,000	>\$75,000	<\$50,000	>\$75,000	<\$10,000
Employment Status	Not Working	Disabled	Employed	Retired	Employed	Not Working
Number Living In Home	4	5	2	1	6	1 Tent Mate
Birth Order	Older of 2	No Data	Younger of 2	Older of 2	Youngest of 5	Middle of 3

Five men were comfortably middleclass and owned their own homes. One man lived in a tent. Four men were married, one man was divorced, and one has never been married. Each man reported between 2 to 10 visits to a health care provider in the last year. Most of the visits have been with their family doctor. One man used the free clinic. The same man visited the emergency room and had recently been in a psychiatric

hospital. Reasons these men sought health care were primarily for medical conditions. Five men reported a history of at least three episodes of depression. Episodes varied in length from weeks to months. Most reported having a low grade constant depression for years. Five men acknowledged treatment for depression and current use of antidepressants. One man expressed his reluctance to get help and to take medication. Two men declined the \$30.00 participation compensation. Every man expressed the hope that by sharing his story about depression he would be able to help other men.

There were some initial inquiries from other candidates expressing interest in the study. One man was excluded because his primary issue was alcoholism. A second man had a major thought disorder. A third man excused himself because this was not a national study.

### **Process**

Volunteers contacted me by telephone or email to express interest in the research project. During our first telephone contact, I explained the scope of the research project and the elements of informed consent related to this particular study. I provided information about the time commitment for the study and the locations of the interviews. Depending on whether the man was comfortable talking at that time I either completed the pre-screening questions or scheduled a time for a follow-up telephone call. The first face to face interview was scheduled for two hours. During that interview each man signed a written consent form to participate and completed a brief demographic survey. He also chose a pseudonym to be used in the study and subsequent reports and publications. The men were invited to talk about their personal history. Each man was

allowed to start his story and to end it when he desired. This gave him the freedom to focus on information holding the most meaning. The initial interviews were audio recorded and transcribed by a professional transcriptionist.

The second face to face interview was scheduled for one hour and was not audio recorded. Each man was offered the opportunity to read a copy of the transcript from his first interview. Participant reviews increase the credibility of the study by using the technique called member checking (Polit & Beck, 2004). Member checking in qualitative research is the practice of providing participants with emerging data throughout a study for their review. Participants have the opportunity to edit the document and validate information. Men were encouraged to read the transcripts which generated a discussion about the initial experience of taking part in the research.

Only one man read his transcript. He said it was interesting. Five other men declined. One man commented that he already knew what he had said and did not need to read the transcript. Another said he would just say the same things again and was sure he would not want to make corrections. The men expressed confidence that the material had been handled respectfully and that transcripts were complete.

In UAPI the participant is offered the opportunity to cooperate in developing a meaningful description of his own patterning profile and he is “the primary source for validating pattern appraisal” (Cowling, 1993, p. 204). This goal was met during the second interview because the men read their individual patterning profiles. They validated the contents of the profile and made additional comments about their overall experiences. Each man was provided with a own copy of his profile. He signed the

original profile document to acknowledge agreement with the representation and to confirm he had received a copy. The signed documents are on file.

Data interpretation began with multiple reviews of the transcriptions and my hand written notes. I listened to the recorded interviews multiple times. At times I just listened to the tapes; other times I listened to the tapes while I read the typed transcripts and my notes. Meanings and experiences derived during individual interviews were connected to create participant patterning profiles. To develop a mutual patterning profile for men with depression compelling and recurring themes which emerged from the individual patterning profiles were blended together with a focus on connectedness.

Cowling's (2004) four types of unitary-transformative knowledge experiential, presentational, propositional, and practical were incorporated into data collection and interpretation for a framework to weave together an emerging image of men and depression. Experiential knowledge gained in personal interviews created an "immediacy of perceptions" (p. 211) and empathic encounters between the co-participants. Personal interviews provided a safe place to share thoughts and feelings. Manifestations of pattern were evident in each man's body language, tone of voice, eye contact, personal hygiene, and clothing; all of which provided additional information about his comfort level, sense of confidence, and the depth of emotions. Experiential knowledge acquisition required active engagement and dialogue. Shared experiences provided the opportunity for mutual reflection and promoted a new understanding of men and their depression.

Presentational knowledge consisted of words and images to more deeply represent phenomena. Men's choice of words during interviews added to presentational knowledge.

They chose their words carefully. They were precise. One man differentiated stress from anxiety; anxiety meant fear. They insisted on exact dates when they related incidents.

Images from art were incorporated into individuals patterning profiles

Propositional knowledge about patterning in male depression emerged during participatory inquiry conversation and self-disclosure. Men offered propositions grounded in their experience. They suggested information depicting how to understand life patterning of men with depression. They felt that many more men have depression than are ever identified. They offered images of what depressed men looked like; withdrawn and down trodden postures. They offered suggestions for intervening with men with depression. Recommendations included changing the language, be more technical, and provide community education. A commonly voiced opinion was that it is not possible to help a man unless he was ready. Practical knowledge emerged through appreciative inquiry about men and their depression. Through the action of choosing to participate, the dialogue of sharing their story, and reflecting on events; men expressed a sense of growth and deeper understanding of their own experiences.

Perceptions, experiences, and expressions were the core facets used to provide descriptive patterning manifestations as visible and experiential projections in unitary life patterning. Cowling (2000), described perception as the capacity for self-reflection and conscious knowing in the midst of an experience. Barrett (1988) expanded perception to a human characteristic which gave meaning to life and encompassed the power to use personal knowledge for change (Barrett, 1988). Interviews revealed perceptions

throughout the man's life; they included his thoughts, questions he asked himself, and what meanings he attached to events.

Experiences include things that happen throughout life; "raw encounter of living loaded with sensation; it involves sensing and being aware as a source of knowledge" (Cowling, 2000, p. 22.) For men with depression some experiences are charged with overwhelming feelings. Others are associated with painful spaces of emptiness and rejection. Expression is the way each man uniquely acts in the world in relation to his depression. UAPI and Rogers support the understanding that wholeness of man's experience is integral with his environment. A man's depression must be explored within the context of his life situation.

The patterning profile for each man was developed based on the information gathered in the exploration of the facets of perceptions, experiences, and expressions. Profiles were written to preserve as much of each man's story in his words as possible while drawing upon and synthesizing unspoken and contextual information. Profiles were developed with the intent to appreciate a holistic representation of each man's unique story in the most authentic and respectful manner. Every man in this study was vulnerable and generous as he shared his story. All the men made it clear they valued a candid representation of their stories and would like to see pragmatic study results. Men then read their individual profiles and were given the opportunity to make corrections and comments that would most accurately and completely convey the nature of their lives as a whole.

The goal of the profiles was to accurately interpret their stories. The goal of the UAPI was to uncover new knowledge about men and depression and to offer men a new understanding of their experience with depression. It had cast a shadow over the men; depression had been useless, limiting, and made them feel less capable. Participation in the research project helped to reduce shame, misunderstanding, and aspects of isolation. The men all expressed the desire that this information would be used to help other men to promote greater understanding and healing. Men felt empowered by the perspective that in sharing their experiences they could help other men. Telling their stories and reframing the experience helped the men feel more expansive and capable of helping others. Men were able to turn their experience of depression into a useful tool to help other men.

### **Life Patterning Manifestation for Men with Depression**

This section is a summary of the stories that unfolded during the first interview. Information was distilled from the interview to capture and illuminate patterns of the whole providing a representation for each man. In UAPI, all strands of the human condition are believed to be closely and importantly woven together. One strand, one facet, of the human condition cannot be viewed separately; it would be misconstrued in isolation. Through synopsis, the strands of each story were amplified and given resonance.

Unitary patterning is conceptualized as integration of perception, experience, and expression into a unique whole, not visible of itself. Manifestations of the patterning of the unique whole are visible. When viewed empirically and documented in research these manifestations of patterning in individual men with depression provide a basis for

understanding and helping men with depression going beyond clinical representations of the phenomenon. The findings are presented in an order reflecting the use of a synoptic process consistent with unitary appreciative participatory inquiry. The order for individual men follows: history, perceptions, experiences, expressions, patterning profile as shared with the participant, and synthesis. Facets of Patterning from individual interviews are displayed in Table 3.

**Table 3**

**Facets of Patterning in Male Depression**

		Participant Number					
		1	2	3	4	5	6
Onset	Child	1997	Child	Child	Child	Child	Child
History of Abuse	V, P	V, P	N	V	N	V, P, SX	
Exposure to Observed Trauma	Y	Y	N	Y	N	N	
Talked with wife about depression	N	N	Y	N	N	N/A	
Treatment Modalities	M, PSY	M, S	M, S	M, T, MC	MC	M,H	
Currently on Medication	Y	Y	Y	Y	N	Y	
Prescriber	GP	GP	GP	GP	N/A	Psychiatrist	
Wants to Help Other Men	Y	Y	Y	Y	Y	Y	

Note. V = Verbal, P = Physical, SX = Sexual, M = Medication, PSY = Psychologist, S = Support, i.e. pastor or friend, T = Therapy, MC = Marital Counseling, H = Hospital, GP = Family Doctor, N = No, Y = Yes

## **Luca**

Luca was born in Colombia and came to America when he was a small boy. He became a naturalized American citizen. He has been married for 18 years and has two children. He moved to North Carolina five years ago because his wife wanted to be near her sister. Luca has tried to lead a good life. He made commitments not to abuse his wife and children. He has worked in the shipping business and made a good living until a year ago when he was laid off. He has been unemployed since then and is worried about providing for his family.

He traces his own depression back to his early childhood. Luca and his younger brother were physically and mentally abused by both parents. His parents beat him with electrical cords until his back was bloody. Then he was sent to the shower to cleanse himself. The next day he would go to school as if nothing had happened. He said the beatings started when he was 6 and continued until he was 14. His parents were violent towards each other as well. The children were witnesses as his mother stabbed his father in the back. Luca tried to get help from the police; but in those days he said it was acceptable to abuse your spouse and children. Marital strife between his parents enhanced his sense of loneliness as his father moved in and out of the home and mother developed friendships with different men. Luca felt so helpless that he even considered killing his parents. Instead he got solace from his Catholic religion.

Events in Luca's life have been less than tranquil. When Luca was still a boy, he was the first one to respond to his grandmother's call for help. When Luca arrived he found his grandfather dead in a pool of blood. The grandfather had a seizure while

shaving and cut his throat. Luca's younger brother never became an American citizen; he got involved in crime, and was deported to Colombia. He is currently living in poverty and Luca worries about him. Luca took classes at the junior college; he hoped to become a policeman so he could help children escape abusive families. During a probation period Luca was accused of some illegal activities. He fought them for several years and was completely exonerated. Unfortunately by that time he was cleared, the window for acceptance into the police academy was closed. During this time Luca had a friend, a policeman, who pulled out a gun and killed himself right in front of Luca. The friend died in Luca's arms. Luca's mother-in-law was killed by a drunken driver.

**Perception.** Luca became depressed as a young boy. He said the police and the mental health community failed to protect him. When he was a boy domestic violence was accepted as a private family matter. Luca thought it was normal to be depressed as a child.

They would come in and beat the hell out of us, and that's not the way it should be. You don't know what to do. I can be very nasty sometimes, and sometimes I think that comes from being so hurt by the one woman that you should look up to. Depression, sometimes you categorize it with people who are losing their mind, and crazy, so you kind of want to get away from that, not be a part of it, but then it all boils down to you have depression, you know, no matter what word you want to define it; but it all is depression.

Although Luca believes that many men do suffer from depression, he said it is hard to convince men to get help. "You're not going to be able to reach out until that person wants to be helped, until that person reaches out himself because if you reach out to someone that is unwilling go get help, they're not going to open up."

**Experience.** Luca to this day says he cannot understand how parents can beat small children so severely. He always wanted his mother to explain her cruelty. She said she thought it was normal. Her own father had broken her arm when she was only 4 years old to discipline her for breaking a vase. This story helped Luca, but did not remove his pain. His parents beat him raw with electrical cords and then made him shower to wash the blood off. The showers were very painful. When he sought help from the police; he was brushed off. To cover up the abuse, his mother reported him to the police. The police threatened him with consequences. He felt betrayed by people who should protect him; his mother and the police.

**Expression.** Depression is a part of Luca that he lives with. Being unemployed for a year has fueled Luca's depression. He says he feels really worthless, like he is no good.

Yeah, I would say I'm stressed. I wouldn't really say depression, maybe, but not often. I might find myself saying to somebody, no, I would go with stressed out. I think I have depression, I say to it to myself. Yeah, stress. Not happy with things the way they are. I mean, and I really cannot ask anybody for help. I want to do it on my own. I want to do what's right. I pray for forgiveness. Life is very short when you think about it, no one knows when they will die.

**Luca patterning profile.** I see the boy Luca standing in the calm eye of a tornado. The wind is dangerous. Swirling around him are events from his life. He is stressed and fearful of the future. There is the terror a young boy feels when he witnesses his mother stab his father in the back; there is blood. There is disbelief when his parents who should love him and protect him beat him with electrical cords knotted together. He

tries to protect his younger brother and accepts his brother's beatings too. His father smashes Luca's face into a bowl of scalding soup hard enough to break the glass bowl. Luca knows it isn't right to beat little kids. Child abuse is a crime. Justice is denied by the institution which should protect children. Luca pretended to have a friend who was being abused. Luca was really talking about himself. Luca stopped a policeman to see if he would protect his friend. The policeman said the law would not do much to protect "Luca's friend who was abused." Justice is distorted and becomes a weapon when his mother uses it to control him by falsely accusing Luca of trying to kill her, his brother, and his sister. The police believe Luca's mother and threaten him with tales of the unthinkable abuses waiting young boys in detention. There is fear when his parents fight. There is loneliness during his father's absences. There is confusion when his mother entertains her new male friends. The boy thinks all this is normal. There is sadness when he sees his grandfather cold and blue, minutes into death. Luca is distressed by feelings that he wants to kill his parents just to end his misery. He does not care about the consequences. The boy finds strength and solace in his church and prayer. Luca is Catholic. He prays to Mother Mary. He prays to Saint Anthony and to Saint Judas, the patron of hopeless causes.

Luca grew into a man. The tornado was still swirling. "I can go on and on." Dates are seared into his brain. He wanted to help other people, especially children. He wanted to be a policeman. He is denied this opportunity because of an unfortunate incident. **July 31, 1992**, he was charged with attempted murder. All charges were eventually dropped and his slate wiped clean. His probation NYPD supervisor discriminated against him

because he was Colombian. The window of opportunity to enter the police academy closed. “Maybe there is a reason.” **August 26, 1995** a friend, a New York City police officer commits suicide. He shot himself in front of Luca and dies in Luca’s arms. In 2005 Luca’s brother was deported for drug charges. In **November 2009** his mother-in-law died when she is hit by a 21 year old drunk driver. “To make matters worse,” Luca got laid off from his job in **January 2010**. In spite of all this, Luca was successful in the shipping industry until the economy and attempts at union organizing cost him several jobs. Now his wife, of 17 years, is talking about moving back to New York. Luca still prays.

He says he is stressed. “Yeah, I tell other people I am stressed. I don’t tell other people I am depressed. I only tell myself that I am depressed.” Depression has been with him since he was a boy. “Depression was taboo. It is associated with being crazy or losing you mind.” He wants to stay away from that word. “I don’t talk to my wife or kids about my problems.”

Depression has formed the man he is today. He tries to be the best father he can. He tries to help other people which is why he participated in this study. Luca felt like the depression has prevented him from reaching his full potential. It makes you feel worthless, like you are no good and fearful for the future. “I want to do it on my own. It is part of me that I live with.” Depression underlies everything else in his life. He has pushed depression, the whirling tornado down into the ground. He works hard to keep it safely hidden. He prays a lot.

**Luca synthesis.** Luca read the profile and loved it. He loved the metaphor of the whirling tornado. Consistent with prior attention to detail, he immediately began adding precise dates to the write-up and wanted to make sure events were in chronological order. The dates in the profile were in bold print because they were so important to Luca. In the time since our last interview he reported that he went to his family doctor. He told the doctor he really felt stressed. December was very hard because his unemployment benefits stopped at the end of the month, Christmas and his wife's birthday were coming, and his wife wanted to travel to New York. The doctor started him on Effexor and told him it could take up to seven weeks to work. Luca reports that the medication has been very helpful. He feels much better; less stressed. He also has had good news. After being unemployed for a year, he will start a new job next Tuesday. It is a job that he really wanted and he says he will like. He also says his wife has changed her mind about moving back to New York this summer and has agreed to stay in North Carolina for at least 2 more years.

### **Chris**

Chris saw the ad in the newspaper. The word depression caught his eye. It is something he has dealt with since 1997. He is 56 years old. He has been married for 19 years. He and his wife are raising his three grandchildren. Life was good. Chris and his wife planned to retire and be debt free when he was 55. They bought a small farm and some horses. He had a good income as an equipment repairman. He was good at his job. He got satisfaction from solving others' problems when he was able to repair their equipment. He had his first back surgery in 1997. That limited his mobility,

interfered with his ability to work, created debt, brought on depression, and started his fight with addictive prescription medications. In 2002, he was chaperoning a church youth group when the tour bus was involved in a horrendous accident that resulted in the death of the bus driver. In 2004, he required a second back surgery. During this time, he had to fight for custody of his three grandchildren (his son's children) who had been first terribly abused by their mother and her boyfriend and then abandoned by them.

He was raised by two hard working parents an alcoholic mother and father. He had one brother and one sister. His father beat him. His father was in the state mental hospital several times for alcohol detoxification. Mostly he was left alone as long as he got passing grades. He played sports; but no one in the family came to watch. He joined the Marines when he was 18.

**Perception.** Chris said when people think about depression no one thinks about what it is really like.

All these little setbacks and things, they just, god, they wear on you. I don't think they sit there and show the small depressions, the ones that eat at you and build up and build up and build up and finally it turns to where you can't get out of the house. You don't know you're that way until you are depressed. Like me, I didn't see it coming on.

When he lost his ability to work he felt like a second class citizen; he was no longer the family bread winner. Depression meant he could not be active. For Chris, depression was a cycle. He would feel better, he would overdo, his pain would increase and, he would get depressed. Then he could only think about money, undone chores, and pain.

Depression and men, it is like a secret club. Oh, it's out there and everybody knows about it, but nobody wants to talk about it. Depression for men is one of those things you can talk to your buddies about, but you can't hardly talk to your wife about, and it's having that feeling that no matter what you tell them it's like the confessional, what you tell them is not going to go outside of this little area . . . as long as you don't break that confidence everybody's good.

Chris said it is difficult to talk to his wife about his feelings because, "I don't want her to think that I'm less of a person than I was with this problem." Chris said it is difficult for health care providers to intervene because men just do not talk about depression and suicide. They just hold things inside.

**Experience.** Chris and his wife believed in the legal system and tried to work through social services to get custody of his grandchildren. The system failed them and that deepened his depression. He needed to engage a private attorney to gain custody. Again that was an unexpected expense. He tried to work in the system to control his back pain. He was enrolled in a pain clinic. The doctor there brought up the subject of depression and Chris started taking an antidepressant. He developed a tolerance to increased doses of prescribed narcotic medication. He was accused of cheating on a drug test. The staff tried to catherize him. That was his turning point. He never went back to the pain clinic. Chris went back to his primary care doctor and told him to stop all the pain medications. Chris ended his narcotic addiction. "That's the other thing too, is dealing with pain for this long or this much a period of time, you get depressed." He has thought of suicide, but he was not overwhelmed with it and has never attempted it. He took some classes at the junior college and diagnosed himself with depression.

Chris still feels like he is not the man he was before. He said pride keeps men from getting help for depression. He said society teaches boys not to cry. He did not want to believe he was depressed. He just doesn't want to talk with his wife about his depression because sometimes it causes problems.

Suck it up and deal with it. I had to hit a point and say, okay, I need to do something about this, and for better or worse, whether I am working on it the right way or the wrong way I don't know. You have to figure out what's going on with you, and then you have to sit there and go to the point say, okay, I'm ready for some help. It's a problem I have and I don't want to hear a condescending word or I told you so or okay you need to go here, here, here, and do this.

**Expression.** Chris likes to be active. He likes to do chores around the house and take care of the animals. He says sometimes he does not listen to doctors when they tell him to avoid strenuous work to protect his back. "I did not handle my depression well at all. I did a lot of drinking, a lot of drugs, prescription drugs, they gave me a lot of pain pills, so and I didn't handle it at all real well, but I learned from it." He says he gets in a bad mood. Chris has to manage his depression. He deals with it by talking with his wife and his pastor.

**Chris patterning profile.** Depression is an uncontrollable accumulation of "small sorrows." These events occur throughout the years. They may be acknowledged, dealt with, and put aside. They are stored in the body and the memory. They are stored in a black hole inside the feelings bank; they are stored in the muscles. They remain covert, hidden away. They fester, they adhere to each other. The small sorrows grow and reach critical mass. It is harder to contain or eradicate these feelings. Sometimes they emerge as

a tumor-like mass of depression. Sometimes they float in a thin skinned taught balloon. Then a major event bursts the balloon. Either way you never really see it coming.

Life was good. When his first marriage ended, he raised his only son. Work paid well and was satisfying. He was able to fix broken equipment. He could make frustrated customers happy again. He used his skills productively. He got rapid intrinsic gratification. He had a strong second marriage. They had plans for the future. They could retire debt free at an early age. They would have a nice farm with a pond and horse stables. Life was interrupted for years by “minor little bouts” of depression. They were manageable. They did not change the major trajectory of his life.

Things changed. The first back surgery was in 1997. The second back surgery was in 2004 and the third in 2011. The last eight years have been filled with setbacks and trauma. Work outside the home was no longer possible. “I felt like a second class person.” Income dropped. The gratification and camaraderie associated with working disappeared. There was the battle for workman’s compensation. He could no longer afford to retirement and run the farm. He was involved in a horrific traffic accident. He performed heroic lifesaving acts. He could not prevent a tragic death.

Life became a constant battle with pain. Pain wears a man down. It makes him “grouchy and moody,” it makes him depressed. Alcohol use increased. Treatment at the pain clinic made things worse. They kept increasing the quantity and strength of the pills. Addiction set in and still the pain persisted. A breaking point occurred, awareness that the pain pills were out of his control. He left the pain clinic and with the help of his primary

care doctor got off of the narcotics. The pain remained but it was less than it was on the narcotics.

Chris's son divorced and moved out of state, leaving his three children with their mother who proved to be incompetent because she allowed the children to be abused by her boyfriend. The social services system failed to protect the children. Chris and his wife went to court to win custody of the children. They have been raising the children. They have gotten them counseling. They have given them horseback riding lessons. They have given the children love and safety.

For Chris, depression means "having to do without." He certainly does not have the income he had. He cannot be as active as he was. He feels better when he can take care of things around the house. He has a tendency to overdo. Then he hurts and has to sit around. That makes him think about his situation and the depression rears up. He calls this his cycle of depression. He has learned to pace himself. He says he did not handle his depression well. He drank a lot and used a lot of prescription drugs. He learned that did not work for him. Depression means hurting mentally and physically. He tried to work it out himself. He does take a prescribed antidepressant.

**Chris synthesis.** I have had a good month. I was in the hospital for one day with my back surgery. I had to wear a brace. My back doesn't hurt now, but I have pain in my hip. We are getting a tax refund for the first time in seven years and are planning a trip to the beach. We haven't had a vacation like that in seven years. That is our deal; if we get enough of a refund; then we can take a vacation. Education helps. Like get the symptoms out there lack of sleep, stress, etc. That's why I have studied this stuff. I am still learning.

Then a guy might say, “Yeah, that sounds like me.” I think the only way for men with depression to get help is if they have a strong supportive wife encouraging them to get help. I just couldn’t see it, the depression, when I was in the middle of it. He brought up the story in the news about a Marine in Afghanistan shooting civilians. You know it’s like that Marine that killed those civilians. I was a Marine and those things that you see; they never go away. I hope that guy gets the help he needs, he was depressed. You know, you are trained to kill. He had tried to get help; but everyone was telling him he was OK and sent him back out to fight. He wasn’t allowed to talk about his depression or get help and he just snapped. The day before that happened his buddy got his leg shot off. His buddy was probably right there (indicates an arm’s length away) and he saw that. It wasn’t his fault. You know they want war now to be clean; but it isn’t and with all the video cameras and the news media presenting instant feedback; this stuff will happen.

“Who’s Chris?” He had forgotten his chosen pseudonym. When he finished he said “Chris could be my twin brother. This summary captured my experience. I couldn’t see events in that order. I would like a copy of this.” Chris has had informal counseling with his church deacon who is a professional psychologist. Chris has also been treated with antidepressant medication. He said both interventions have been helpful. He talks less frequently with his deacon about the depression now. He does take Wellbutrin and he knows it helps. If he stops it for a week, he begins to feel less tolerant and tears up more easily.

Some of Chris’s experiences were difficult to listen to. The first was the bus accident. The bus overheated in five lanes of traffic on an Atlanta highway. It was full of

school children. Chris was a chaperone. The bus just stopped. The bus had a reset valve that needed to be operated by opening the rear hood of the bus from the outside of the bus. The driver got out of the bus and was resetting the valve when a car smashed into him. The man was almost bisected. He was airlifted to a hospital and lived 3 days before dying.

The second story was about the severe abuse his grandchildren were subjected to. The mother's boyfriend was the perpetrator. The little boy was disciplined by putting him into a cage with a boa constrictor. The girls were sexually abused. Even so, social services were reluctant to remove them from their mother's custody.

### **Mr. W.**

Mr. W. is a 56 year old highly educated married man. He saw the ad in the newspaper and his wife, a mental health counselor, encouraged him to participate in the study. He said they both support research and higher education. He took some psychology classes in college and had been involved in research studies before. He is technologically orientated and teaches weeklong workshops to other professionals all over the country. He has two adult children. They both have master's degrees and are married. Mr. W. is anticipating the birth of his first grandchild.

His mother had high expectations for her two sons and emphasized that the W's were "Better than anybody else. W's" don't get those kinds (emotional) problems." Mr. W. believes that is why he is such a perfectionist and has trouble tolerating short comings in other people. He was attracted to the word depression in the ad but says he does not have depression; he has anxiety. He is fascinated that his anxiety is reduced by regular

use of an anti-depressant medication which is prescribed by his family doctor. During our initial telephone conversation Mr. W. said he thought he might be able to help with the research, but adamantly stated that there could be “no feeling words” used in the interview. At the follow up session he said he had not learned a feeling vocabulary during childhood and he was envious of his own daughter who had had “feeling flash cards” from an early age.

**Perception.** Mr. W. had an understanding from childhood that, “We (men/boys) were the strong ones, the rock in the family, that kind of thing.” The message was perfuse in the culture of being a boy; he never was told that directly by his parents.

Men are conditioned to say there is nothing wrong with me. It was always okay to have happy emotions, to laugh or smile but not acceptable to have negative emotions. Depression means having the blues, feeling dejected and not being able to get out of bed. Men don’t like to say, yes, were depressed, because we’re not in touch with most feelings. Men are taught to soldier on . . . when it comes time to grieve, we grieve our own little way in our own little personal compartment over here and then that’s that.

Mr. W. says that for most men depression represents weakness; a personal failing.

**Experience.** “I wouldn’t say that I am depressed.” His relationship with his wife is very important to him. When he raged over the lawn mower not working it was a red flag. His wife suggested he get help. He went to a counselor. After talking it seemed clear to Mr. W. that he did not meet the criteria for depression. However, he went home and researched depression on the internet. He scored 5 points on a 10 point depression screen. This self-assessment was an eye opener for him. He was surprised when the counselor suggested he start taking antidepressant medication. The medication helped. Mr. W. said

the mood dysphoria does affect other parts of his life. He believes that he could have been more successful in his career if he did not live with anxiety. The anxiety has had no benefit, it has proven to be debilitating. He also says it plays a role in his marriage, although both he and his wife have developed ways to cope with it. He says she is very understanding and allows him extra space to recharge his energy. Mr. W. has learned he has to deal with and manage his moods.

**Expression.** He describes himself as a control freak who has little patience and, “Who doesn’t suffer fools.” Mr. W. would get really angry at small things, like the lawn mower breaking. Once his wife had expressed concern about his moods, he was completely open to getting help. “I tell all my friends that I’m on antidepressant drugs.” Mr. W. suggested using the word stress when talking to men about depression. He said he thinks many more men would present for help. Also, he recommends talking about a medication to treat the chemical imbalance in the brain rather than call the medication an antidepressant. He is more comfortable with the concept of having a chemical imbalance in his brain because that becomes a medical condition, and can be fixed and not a personal failing.

**Mr. W. patterning profile.** Star Trek—23<sup>rd</sup> Century. Meet Mr. Spock, the embodiment of the “mystery of masculinity” (Jenkins, as cited in Ulaby, 2008, “Emotion vs. Intellect,” para. 5). He is not influenced by emotions; he uses logic to live a rational life. He is fascinated by the infinite nature and diversity of the universe and its inhabitants. He maintains a healthy distance and skepticism about his universe. His stoicism is a gift from his Vulcan father. The Vulcan culture eschews emotions and

values logic, rationalism, and technology. Spock also receives a gift from his human mother. Spock feels human emotions. He is subject to some internal conflict. Spock studies long and hard not to acknowledge any emotion, and yet occasionally he experiences a feeling. He works to be in control of his emotions. He sees danger in emotions because they can interfere with rational thought. ZING, SSSS, SPLAT . . . Earth–21<sup>st</sup> Century.

Meet a man, just an ordinary man. He is a human being who experiences internal conflict, human feelings, and expends energy to maintain control of his emotions. He is logical and likes to find solutions to problems. He is a technology expert; that is how he makes a living. The man moves forward through life, like a soldier in the face of pain and adversity.

Feelings fall into categories. He does not want to be numb to his world. A moderate amount of positive feelings are acceptable. Grief is a necessary and expected part of life. It can be dealt with in a logical manner. It can be compartmentalized and controlled. Negative emotions serve no purpose in a logical technological world. They can be very scary. They can be terrifying; they are illogical. They can be dangerous and interfere with rational thinking.

Then there is anxiety. In a mild form it can motivate one to improve performance. A short term acute anxiety may be useful. It can serve as an alarm system to warn you of danger and keep you out of harm's way. Persistent anxiety has a different effect. It puts the system in a constant "flight" state and floods the body with stress hormones. "It affects me in multiple ways. It prevents me from moving forward and achieving all I can.

If I don't work on the anxiety it disrupts my relation with my wife. I hold my feelings close. I only talk about them to my wife if she asks."

The word anxiety and the feelings attached to it have electrical zings. Anxiety emerges as a technical commodity. It can be objectified. There are logical solutions to anxiety. Anxiety is a problem to be solved in chemistry class. Relief from anxiety requires the precise titration of serotonin and recharging the energy system. Systems need to recharge, don't they? Anxiety is alleviated by daily ingestions of antidepressant medication. Can anxiety be a form of depression?

Depression is an unacceptable feeling. Depression means the blues, not getting out of bed, weakness. Depression is scary; it means that "Something is wrong with me, inside of me, in my head. Something is wrong in my brain." The brain is the supreme computer, the ultimate control center. Depression is not logical, it isn't practical, it has no useful purpose.

**Mr. W. synthesis.** Mr. W. enjoyed his profile. He planned to show it to his wife. I shared my own thoughts about the profile. ZING, SSSS, SPLAT . . . was used to represent the concept of energy for two reasons. First, I saw the anxiety as a static energy; capable of producing an uncomfortable shock. Second, energy is the basic structure of the electronic/technology based field Mr. W. specialized in. I sensed in Mr. W. that he valued being a good and ordinary man. He wanted to be in control of his life and at times emotions were the least controllable part of life. Mr. Spock from Star Trek was used to represent the concept of the ideal male, absent of feelings and operating completely from

a logical stance. Mr. W. felt the profile best summed up his experience with the sentiment that anxiety (depression) is a problem to be solved in chemistry class.

Mr. W.'s anxiety may not have been true depression in the clinical sense. However his contributions to this study were valuable. He did in fact respond to the ad because of the word depression. That supported the possibility that men who may not be able to identify themselves as having depression, but who do have depression, would be better served if health professionals used stress as a starting assessment point.

### **Gus**

Gus saw the flyer at the public library. He responded to the word depression. He has felt like he has been mildly depressed for 20 to 30 years and has had 2 or 3 episodes of severe depression. He is a divorced white male in his 50's. He was raised in a traditional family unit; mother, father, one sister, and himself. Both of his parents and his sister suffered from depression. There was no physical abuse or exceptional events. His father was verbally abusive and emotionally remote. Positive reinforcement did not exist; it was always, well you could have done better. Gus has accomplished a lot. He served in the military. He earned a bachelor's degree in business and economics. He worked 28 years as a paramedic. He went back to school and became registered nurse. He volunteers as a nurse at a community clinic. He knows the depression has impacted every part of his life; his family, his marriage, his career, his quality of life. Gus said that how he managed his depression was the reason his marriage ended. He failed at several promising careers due to depression. He said men need to be "hit on the side of the head" to admit their depression is bad and they need help. His wake up call was an arrest for driving while

intoxicated and being handcuffed to a hospital bed. He is recovering from his episode of major depression. He still watches too much TV and has trouble initiating activities but he is much better than 1 ½ years ago.

**Perception.** He never felt like his parents were devoted to him. He was afraid of his father. His father spoiled family Christmases. His father would just sit there and not speak. He would be, “Pissed off.” He could be mean and standoffish. “He was the man, and he let you know that, and I realized that’s good to a point. I mean somebody’s got to be in charge.” He remembers thinking something wasn’t right with his family; that it was not a normal family. Depression is a scary word; it breeds denial. “I’m not depressed, I’m just pissed off.” Depression, “It’s too, not feminine, but it’s not manly. I don’t think of it as something a man has; must be tough, and if you’re depressed you must be weak. You are vulnerable. You have chinks in your armor.” Stress is more acceptable to a man. It is an outside force that you have responsibility to deal with. “Depression is up here something that is in you, that’s you, that’s in your mind. If you’re depressed it’s your fault. Depression is you.” Depression is a mental illness. “I’m not crazy.” “It might help some men get help with their own depression if a pro football player admits he has suffered from depression, but others would say, well he’s a pussy.”

**Experience.** At work his attitude or the way he reacted to stress interfered with progress and advancement. Gus also said he had post-traumatic stress disorder from his work as an EMT. Management encouraged paramedics to get free counseling and attend debriefings but most people did not go. He lost interest at work and became one of those people who just showed up. At home his wife said he was not forthcoming and did not

share his feelings. Things continued to deteriorate in spite of marriage counseling. He drank more and gained weight. He started to snore. He felt really hurt when his wife moved out of the bedroom because his snoring interfered with her sleep. He said that, “Seemed to push me over . . . and rather than work on it, I didn’t . . . I didn’t realize it at first, but after losing a wife and a couple of careers and being locked up for drunk driving, I figured it was time to do something about it.” His only male role model had been his own father. When he emulated his father’s behavior, it damaged his relation with his own sons. His trouble with the law, a driving while impaired episode, really scared him. He said it was his fault and was, “Directly a result of being depressed and the way I handled the depression. . . . I realize it’s just a vicious circle, the more you drink, the more depressed you get.”

**Expression.** As the depression got worse, Gus drank more and withdrew. He increased his alcohol intake from several times a week to daily. He started using other substances. Some of them were illegal. They were medications that were easily available where he worked as a paramedic.

I enjoyed it. It was fun; I was living on the edge. Depression seriously affected my life . . . family, marriage, career, everyday relationships, everything. The way I acted when something happened to me from total stranger or getting pissed off at the grocery clerk, you know. It inhibited my ability, my incentive.

**Gus patterning profile.** “Mildly depression for 20 or 30 years . . . last 4 or 5 years pretty severely depressed.” How does a man know he is depressed? How does he wake up to the fact? Depression plagued him for many years. Gus grew up with verbal

abuse and knowing that he could never meet his parent's expectations. He felt inadequate, not good enough, and not capable of achieving. His mother was depressed.

Depression was occluded through different life stages and different successes. A college degree in economics, a career as an EMT, a second career as a registered nurse, managing two careers nursing and emergency medical technician were all balanced with marriage and parenting. Mental health classes in nursing school and working in emergency medicine failed to uncover his own depression. Yet the depression was there. The depression was seen by others as his having a bad attitude. Gus said he felt angry and stressed. He lashed out. Depression interfered with his career advancement. He lost "several careers."

Depression interfered with his marriage. At his wife's suggestion they tried marriage counseling. His wife said he was not "forthcoming." Gus admitted he did not try very hard. He withdrew from the relationship by working more hours and drinking more alcohol. He gained weight; he began to drink more and every day. He knew the alcohol was making him more depressed. He began to snore. His wife moved out of the bedroom because she could not sleep. Gus did not work on changing to make things better with his wife; he just accepted the move as a mortal blow. They divorced.

Depression is an "insult, I'm just pissed off." Gus denied his depression. He worked against being depressed. Women get depressed; it is not manly, it is weak. "Depression is up here, something that is in you, that's you, that's in your mind. If you're depressed it's your fault . . . maybe it's not your fault." "Depression is a mental illness. I'm not crazy."

Work, sleep, drink; work, sleep, drink; work, sleep, drink; and a little drug use finally made him admit he was depressed—very depressed. He lost interest in work and became “just one of the people.” He had a 28-year career to protect. He continued to live with his pain in his circumscribed world.

Then “a slap on the side of his head” got his awareness. He was finally ready to do something about his depression. He got a DWI. He says the depression led to the alcohol use which led directly to the DWI. The depression got out of control. For the last year he has been seeing counselors, taking medication, and stopped using substances. He has better control over his depression. He can talk about it now.

### **Gus synthesis.**

I am okay, money is okay, legal is settling down, and I am out of a stressful job. The court stuff is done and I have one more year of driving on a restricted license and monthly meetings with a probation officer. That’s a pain but it is okay. I just got a call today to return to my volunteer job as a nurse at the clinic. It is just past me now. I want to be able to help my mother.

In regard to helping men with depression, he responded that asking men about depression is too direct, maybe you could ask them about symptoms. He admitted it was a big leap to admit you have depression even if you identify the symptoms in yourself. “Denial is a big thing.” Medication and therapy were both helpful, “I did them both.” He tried to stop his medication one time and could tell the difference. He knows he needs to stay on the medicine. He read the profile and said it accurately represented his experience of depression. “I would say the same things today.” He expressed interest in reading a final cumulative summary of findings.

## **Joshua**

Joshua is a 46-year-old married white male. He saw the flyer at the library. He responded to the word depression. He was experiencing marital problems and thought he might have to move out of the family home. He was looking at the bulletin board for a rental. He works in health care. He is competent at his job. He is a good provider for his family. He said he has an underlying depression that was always with him.

He was the youngest of five children. He had to fight for respect and to be heard. His older siblings were always smarter and more capable. He was raised a Catholic. Now he calls himself an agnostic. He has experienced three or more episodes of severe depression. He says he was depressed in high school. He loved to run and that served to stave off the depression. He would run for hours. He also started to drink alcohol in high school. He has always used alcohol both to mask his depression and as a reward. He was depressed after he finished college. He moved to a big city and was alone. He was fired from his first job and he sank into depression for more than six months. He did not tell his family he had lost his job or that he was depressed. He even lost interest in running. He drank more. At times of increased marital and family conflict he had been depressed.

**Perception.** His perception was that he did not even know he was depressed, “When you’re in it all the time, various degrees of it, you may not even be aware that you’re depressed, you know, because it’s just the state you’re in all the time.” Joshua and his wife have tried marriage counseling. He did not like it because he felt it quickly turns into a blame game; and he was usually the one who was wrong. His wife wanted to see a Christian marriage counselor. He believed that a Christian counselor would tell his wife

that the marriage was hopeless because Joshua and his wife did not have the same Christian values. He thought a Christian counselor would tell his wife to leave him. He has thought about suicide in the past but he figured things would always get better. He felt like his marriage was a wild roller coaster ride. Joshua said guys saw going for help with depression as a sign of weakness; it was something girls did. “For a man to get counseling means he isn’t strong; he isn’t confident. So to go and spill your guts on somebody, you know, that’s an emotional quality that men aren’t supposed to have. We’re pragmatic, we stick to the facts.” He thought other people didn’t want to talk to him. He said he could tell by their body language.

**Experience.** Conflicts with his wife and oldest daughter are sources for his depression. Joshua feels very hurt that his wife values him so little and, “Would so easily throw me out.” He has good relationships with his son and his youngest daughter. His oldest daughter is indifferent to him. In the past she was angry with him. Now she just talks to him when she needs money or a favor. He is baffled and very hurt by her behavior. He had a wakeup call; he was in a motor vehicle accident and was cited for driving while impaired. He feels selfish now if he takes time away from his family to run. Depression has, “Affected my self-confidence and hurt the quality of my life.” His lack of self-confidence prevents him from reaching out to others. He is very lonely.

**Expression.** In high school he ran 50-60 miles a week. He found it was impossible to be depressed when he ran. He was good at running and it gave him confidence. When he finished running; he would drink. He began drinking more and more; it just crept up on him. Depression has been expressed as anger. “I have periods

where I just lose my temper and I think it's because I don't feel competent then, or good about me, so it comes out in bouts of anger over like stupid stuff, you know, that really shouldn't matter." Joshua has never had individual treatment for depression and has never taken medication.

**Joshua patterning profile.** The search for recognition and respect started early. Born the youngest of five children, he lived in the shadow of his older siblings. They were of course bigger, stronger, smarter, and faster. Mom said, "Let your older brother do that, he can do it better." Joshua's self-esteem withered. Mom meant no harm; she was just in a hurry. Depression began in high school. He ran. He was good at running and it gave him self-confidence. "It's impossible to be depressed when I run." When he was finished running, he quenched his thirst and rewarded his effort with beer. That became his lifelong routine: depression creeping up, running 50 to 60 miles a week, and drinking beer as a reward. After college he had his most severe episode of depression. It lasted about six months. He was alone, lonely, and out of work. He did not tell anyone. His family thought he was hard at work in the big city. He was spending his savings to survive. He did not run much; even running didn't help. He drank more. He is older now. He has a wife and four children. He works full time and fills in as needed at a second job. He runs less. He drinks less. He was cited in a minor motor vehicle accident after he had been drinking. That was his "wake up call" to drink less.

"When I am in depression all the time, various degrees of it, I'm not even aware of it, because I'm in a constant state to some degree." Depression started in high school. It has been with him ever since. It has always been there. It is always there. It does not go

away. “There has been an underlying depression all the time; probably for years.” “It’s just the state you’re in all the time.” Sometimes the depression erupts in anger over little things. It happens when “I don’t feel competent and good about myself.” Depression has reduced the quality of his life. He basically feels like he is on the outside looking through a window while everyone else is getting on with their lives. But Joshua remains totally disconnected. “I’m not welcome, I’m not good enough, I’m not smart enough or religious enough or talented enough, so I have to just, I live on the fringes.” Suicide is not an answer, because, who knows things can get better.

The famous painting “The Scream” by Edvard Munch comes to mind (Wikipedia, n.d.). It depicts a man showing the world his distress by screaming aloud. In Joshua’s story, the screaming is silent; it is internal. Joshua is a man standing alone. He does not feel welcome in the family circle. From the perimeter, he is desperately calling to others, “Hey, Look at me! I’m here! I’m your son, I’m your dad, and I’m your husband! How can you throw me away?” He lives in an existential universe of the absurd (Gaarder, 1996). He accepts responsibility for his own actions including a brief violation of his marital vows. He accepts responsibility for his values which include his going, “To where I’m essentially a nonbeliever, I’m an agnostic.” He knows he can be a good person without a strong faith. Exercising free choice he has made pragmatic decisions to give up some freedoms and devote himself to his family. He defines himself as a good man and cannot understand why he is lonely, why his own daughter is indifferent to him, and why his wife cannot respect and value him.

**Joshua synthesis.** Things have been a little better at home. His wife has not been talking about a separation. He was really struggling with family issues. Several times during the interviews he asked if he was OK; seeking reassurance that he was not crazy. Joshua acknowledged his depression and related it to marriage and family conflict. He did not acknowledge some of the origins of his problems. He said the primary gulf between him and his wife was different spiritual beliefs. He minimized an extramarital affair he had ten years earlier. He said it was very brief and a dumb mistake. He said he was having a midlife crises. He was noticing changes in his body and losing his hair. He was surprised a woman showed any interest in him. Somehow his daughter found out about the affair. His daughter has been angry, aloof, and cruel to him. Her behavior really hurts him. He read the profile and got tears in his eyes. He said it was good, it felt like him. “Oh, I don’t want the gift card. This has been like free therapy.”

### C. J.

C. J. was the youngest participant. He was 21 years old. He had been moving around since he was 18 and he currently lives in a tent. He saw the research flyer at the soup kitchen and responded to the word depression. C. J. was the younger son in a family. His parents divorced when he was three years old. He has few childhood memories. He remembers his parents fighting. Then his father left. C. J. says he was happy for a brief time before his mother remarried. The second marriage produced a half-sister. C. J. said his step-father got along with his older brother and adored his own daughter. Anything that went wrong was blamed on C. J. The second marriage dissolved and his mother remarried a third time. She was happy in her new marriage and told C. J.

he could no longer live in her home. His biological father remarried and has been devoted to his two younger children.

C. J. was lost in the middle of a twice blended family. He was adrift at sea and has never found the shore again. When he was eight years old he was molested by a 16-year-old neighbor boy. He did not tell his parents. He was afraid to go outside. C. J. knew he was depressed in high school. He asked his mother to get him help. She said he was just a teenager and ignored him. His pain was so intense he started drinking and using drugs. He was addicted to aerosol sprays and one time was found passed out in the school bathroom. He cut on his arms. He ran away from home. His younger sister found him on the floor having a seizure. At last he got help. He was diagnosed as severely depressed and started on medication. He finally felt better and in control of his moods. It was two months before graduation and his mother pulled him out of school saying he would never pass. When he was 18 he left home and finished high school. He was proud that he has graduated. He has had several psychiatric hospitalizations. He has been suicidal.

He lives with roommate in a tent. He came to North Carolina to be far away from his family. He says he cannot work because of the seizure disorder. He continues to use marijuana; he believes it is effective in preventing seizures. He says he is writing a book. He would like to go to college and be a high school teacher someday. He says he wants to help kids who feel as bad as he did.

**Perceptions.** C. J.'s perceptions contributing to the wholeness of his life began early. He said "I figured that nobody even cared about me being born, and I often think like, you know, my birth, my parents just, they regret the whole thing." "It was just like,

nobody cared about me.” C. J. was lonely; he said his friends and family always put him down. He believed one uncle cared about him because the uncle stopped using drugs when C. J. was born. That uncle died young when he suffered from a gunshot wound. C. J. said that he has benefited from medical interventions for his mental illness. “Well, if I would have gotten it earlier, I think a lot of things would have changed; like I probably wouldn’t be in this situation right now.”

**Experience.** C. J.’s early experiences increased his vulnerability to depression. He had a family history of drug abuse on his mother’s side and alcohol abuse on his father’s side. No one in his family has a history of depression. His father left the family when he was three and C. J. said he had no strong father figure. He learned to drink at home when he was 12 years old. He said in his home the drinking age was reversed; it was 12 not 21. “I noticed that I was sadder than other kids.” “I think the main thing about me not feeling wanted was my step-dad the way he treated me . . . I wasn’t old enough to understand anything.” His step-father abused him. When C. J. cut on himself, his mother would ask if the cat had scratched him. He was molested and told no one. C. J. said it was hard to visit his uncle after the gun shot because even though the uncle lived three more months, he was suffering and dying.

**Expression.** C. J. expressed his depression by acting it out. He started “drinking in school cause I couldn’t go through the day.” He took plastic water bottles filled with vodka to school. He inhaled aerosols. “I was just living day by day, doing whatever I could get my hands on.” “I’d do that, you know, trying everything to self-medicate, just

make the pain go away.” He started to get in trouble with the law. He repeatedly asked his mother for help.

Now he is trying to stay on his medication by taking it every other day to make it last. He does not have \$4 to get his prescription filled. He has applied to Christian Ministries for help getting medication. He is trying to get on Social Security Disability due to seizures. He is accepting a sick role.

**C. J. patterning profile.** A general blueprint for creating a psychologically resilient adult might include the following elements. Parents making a commitment towards the child backed with love. The parents would accept the child as a worthwhile person unconditionally. Parents would provide for the safety and wellbeing of their child. Parental guidance would help a child develop strong self-esteem. As mentors and teachers, parents should engender a child with socially acceptable behaviors. The parents would provide a strong emotional foundation which the child internalized. This internalized emotional foundation would later serve as the basis of the child’s future perceptions, experiences, and expressions. Without careful attention to the blueprint in constructing a building or a life; cracks can form in the foundation. These cracks can turn into fault lines which weaken the entire structure and make it more vulnerable to stresses and strains. Of course every person is unique and has unique experiences.

This is how C. J.’s unique experience fits into the blueprint. Loving parents begin by welcoming their new baby. “I think my parents regretted my birth.” Parents provide a safe place for a kid to be a kid. His first memory was of his biological parents fighting. Later, his stepfather was abusive to him. The family asylum shelters a child from harm

and dangerous external elements. When he was 8 a neighbor molested him. “I never told my parents. I stayed in my room for a week. My dad yelled at me and made me go outside.” Parental supervision provides socialization and role modeling. “I didn’t have a strong father figure.” His biological father left him when he was three. “Mom and my stepdad worked all the time.” “I raised my little sister.” “In my home the drinking age was reversed. It was 12, not 21. I started drinking with my family.” He has an older brother who got along with stepfather #1. His younger sister is his half-sister. C. J. was lost in the middle of a twice blended family. Parental attention towards their children fosters a sense of well-being. Nobody paid attention to C. J. They did not care how he felt. He was a powerless player in his family. “I told my mom I was depressed and she didn’t listen; she said I was just a teenager.” He had to do things to make her believe him; he cut himself and he ran away from home. He considered suicide. He inhaled aerosols; anything to get away from his life. In high school he started to take a plastic water bottles filled with vodka to class every day. His friends told him that was not a good idea. They taught him to smoke marijuana. The pain went away. At 17 he was diagnosed with seizures and serious depression. When he had two months left in high school his mom took him out of school. When he turned 18 he left home, went back to finish high school and got a diploma. He has been homeless since he was 18. He will be 22 soon.

What did it mean when C. J. said his depression was terrible pain inside? “It was just that nobody cared about me.” That was as expressive as he could be. Depression and pain are such non-descript words. They are weak words. They are insignificant words. The pain of his depression was a tortuous, writhing, and constant sensation. His

depressive pain cannibalized his humanity from inside. He had no way to deal with it. He was powerless when faced with the depression. He had no resources, no skills for coping with it, and no support system. He had to overwhelm his depression; he had to numb himself. The secrets are inside. The secrets are still holding him in the grip of depression. The gaping deficits from his childhood are open internal sores. They are still eating away at his self-esteem; his life. There are not many healthy rewards in C. J.'s life to lead him out of depression and foster contentment. He tends to have only transient relationships. The awareness and pain of depression can still be blotted out with drugs and alcohol.

**C. J. synthesis.** C. J. agreed to a second appointment. When I contacted him to schedule a second appointment, he said he wanted to meet the next day. He chose the date, time, and place. He did not show up for the appointment. He did not contact me again. I wanted to use his information because I felt he had offered good insight into what adolescent depression looked like and how it influenced lifelong behavior. He said I had asked him more questions than any doctor or therapist ever did. Our session together was the first time he talked about his experiences. I believe the intimacy of the interview was too frightening.

C. J. lived at the perimeter of what a young man needs for existence. He had no permanent shelter, and relied on the soup kitchen for food. He was at the mercy of the weather and whatever other malevolent forces he encountered. His clothing was tattered. He was cloaked in the odor of poverty and it took several days to air the office out after his visit. He was the human equivalent of Humpty Dumpty. He had not been protected as a child; he had been placed out of sight and out of mind on a precarious shelf. He did

tumble down. He was left with shattered pieces of himself and some of the fillings have leaked out. He alone had to pick up the pieces. People walked past him and tried to avoid any interaction. There were gaping holes in his being. He was left with substance abuse issues and a seizure disorder. In seeking pattern appreciation of C. J.'s unique wholeness one sensed an innate goodness. There was hope that C. J. might be able to build a better life. He did seem to have a strong sense of self and some goals. He has been homeless for four years and managing.

Common facets of patterning emerged quickly as each interview followed the ones before. To begin with every man stated that his main reason for participating in the research project was to help other men with depression. Every man voiced the opinion that many more men suffered from depression than ever sought help. Individual stories demonstrated how each unique life pattern developed along a spiral of complexity throughout a life span. Even though no interview questions were asked about families, every man talked about his family of origin and his current family situation. The men all identified themselves as decent men who tried hard to do good things for their families and their communities. Table 4, Individual Manifestations of Patterning in Male Depression, is a summary of perception, experiences, and expressions illuminated during the collective interviews.

**Table 4****Manifestations of Life Patterning for Men with Depression**

Perceptions	Experiences	Expressions
Something wrong with me	Easily angered or frustrated	Compartmentalized feelings
Dangerous	Loss of control	Increased substance abuse
A threat	Minor brushes with the law	Bleeds into relationships
Weakness	Fix it myself	Critical of self
Something wrong with my head	Researched depression on internet: self-screening	Only talk with wife when she asks me about feelings
Men don't get depressed	Antidepressant medications brought relief	Treatment from a trusted primary health provider
The blues/not getting out of bed	Isolation	Failure to or just not making progress in life goals
Men have stress	Uncomfortable with the word depression	I would never tell another man I am depressed, stressed yes, but never depressed.
Depression means you are crazy; really sick	Work hard, clamp down on emotions	I am a normal guy
Nobody listens	Formal system failure	Desire to help others

**Mutual Manifestations of Life Patterning for Men with Depression**

This section explores the mutual life patterning for men with depression. Mutual life patterning profiles were created to retain as much of the individual men's stories as possible while seeking unifying patterning among men with depression.

During the interviews six themes emerged spontaneously and were recurrent among multiple participants. They are summarized in Table 5.

**Table 5**

**Mutual Manifestations of Life Patterning for Men with Depression**

Depression	Serves no purpose. Prevents me from being as good as I could be. Reduces the quality of my life. Men aren't supposed to get depressed, so they don't see it. Men are unaware they are depressed while they are depressed. It just creeps up on you. Shame. Unworthy. Stress. Lonely. Inadequate. "Men don't have words for emotions." Pain.
Paths to Depression	Physical abuse, molestation, emotionally remote parents, genetics, physical pain, trauma, rejection, low self-esteem, early onset anxiety.
Expressions of depression	Irrational and unpredictable anger. Bad mood. Grouchy. Increased substance use. Risky behaviors. Tears.
Normalization	I am a good person. I work hard. I provide for my family. I am a normal guy; I have a boat, I like football. I want to help people. I take care of an elderly parent. I am not crazy. I don't have mental illness.
Living with depression	It's something that has to be dealt with. I wanted to do it myself. It is not who I am. Men live with depression for a long time before getting help. Men need an outside event or trusted person to help them acknowledge their depression. Depression is kept inside while going about daily living. Pride keeps men from getting help.
Helping men with depression	You can't help them until they are ready. Help them fast with a practical intervention. Red flags. Primary Care Provider is the portal to treatment. Men will do medication. Change the language; be more technical. Use "stress" instead of "depression." Educate men; teach them depression is not weakness or being like a woman.

First was the experience of depression. Not one participant identified anything positive or transformative about the experience. Most men said they really were not aware they were becoming depressed or even knew they were depressed. They did know that something was not right; they were not as effective or successful as they wanted to be. They felt shame, stress, inadequate, and unworthy.

The second theme included the life events or pathways into depression. Each man identified at least one of these factors. Some men had experienced several. Pathways to depression included physical pain, trauma, rejection, low self-esteem, early onset anxiety, physical abuse, molestation, emotionally remote parents, and genetics.

Expressions of depression emerged as the third theme. Men engaged in riskier behaviors. Several were charged with driving while intoxicated. Several began to misuse illegal drugs or prescription medications. They exhibited mood disturbances and irrational and unpredictable angry outburst. Some couldn't stop crying.

The fourth theme to emerge was the struggle to maintain a normal life style. They tried hard to maintain an image of themselves as "normal guys." They wanted to fix this problem, depression, by themselves.

Living with depression was a persistent theme. The men did not talk about being depression free. They talked about managing it with medication. They talked about pacing their activities to prevent relapse. Most men had identified a personal warning sign to alert himself to get some help; maybe a change in medication. Men were comfortable taking medication because they found them effective. Men went to their family doctor for treatment.

The last theme was helping men with depression. They all stated an interest in helping men with depression. In their own personal way, each one had given support to another depressed man. Men suggested public education campaigns explaining depression to men and to let other men know there is effective treatment. Men needed to learn that depression was not a personal weakness. The men suggested using words like stress or describing symptoms which men could readily understand.

All of the men had suffered from depression for many years. Additionally some had experienced several episodes of severe major depression. It was a defining facet of individual patterning manifestation. Yet depression was an internal process which was kept hidden from others as these men contended with the daily responsibilities. They had all learned to live with and manage their depression. Five men were in active treatment and/or on medication for their condition. Three of them have thought of suicide. Several saw their participation in this research project as therapeutic and part of their healing process.

They agreed that helping men with depression was a difficult task. Suggestions included education. Many of these men had made efforts to learn about depression, medication, and counseling options on the internet. Some had taken psychology classes in high school or college. Luca said maybe it would help if survivors talked to groups of high school students like survivors of drunken driving accidents do. Joshua said, "Tell them going to get help is not a sign of weakness." The men suggested changing the perception of depression as a woman's affliction. Change the concept that depression is associated with mental illness. Mental illness meant insanity to these men; it was like a

fatal internal disease process. It meant something was really wrong with them, it was a threat to their personhood. At least 3 of them said to change the word from depression to stress and crowds of men would appear. They wanted the health care professional to change how they presented depression. The men wanted it presented as a biological or chemical problem; one that responded to pragmatic interventions. Several men said they wanted practical information. They could process the diagrams about selective serotonin reuptake inhibitors blocking chemical portals in the brain and rebalancing neurochemicals.

They agreed that men are not going to get help until they are ready. But when they do ask for help, they want it fast. Chris brought up an incident in the news about a Marine who had killed civilians. Chris said the guy asked for help with depression a week before the tragic incident. Chris guessed the Marine did not get the help he needed and then just “snapped.” Several participants said men hold their emotions in until they snap. Joshua said, “These people that randomly go into schools and start shooting, 9 times out of 10 they’re guys. You don’t ever hear about a girl doing something like that.” They all agreed that sometimes they could spot depressed men; but other times they really didn’t know until something happened.

### **Life Patterning of Men Seeking Help for Depression**

This section seeks to understand how men chose to deal with depression. Some areas of interest included what needed to happen for a man to acknowledge his depression, what decisions did he make to allow himself to get help, and from whom does he get help. Each man in this study at some point looked at his depression head on

and through introspection made a decision about how to manage his own life patterning of depression. He exercised knowledge of his condition and his personal power to initiate a healing change (Barrett, 1988). This volitional act created a re-patterning of his human and environmental fields (Rogers, 1986). Ability to engage with and work with the depression is one reason these men were able to choose to participate in a research project about men and depression. Several men said they participated in this research process to further their healing process.

All of the men in this study have accessed treatment for mental health within the formal health care system. Two of the men had been in couples' therapy with their wives. Five of the men had been seen individually for treatment. Five of the men are currently on antidepressant medication which they receive from their primary care physician. One got medication through the community mental health system. One man was a health care professional and is wary of medications.

Only two participants were originally able to identify themselves as being depressed. Most needed some outside prodding before admitting they had depression and allowed themselves to get help. The men required a trusting relationship with their care provider and most sought help from their long term family doctor. For some of the men it was a trusted person, a spouse or a physician, bringing the depression into field of vision and giving them permission to get help. For others it was interpersonal problems at work or trouble with the law.

## Summary

Stories shared for this research study illuminated facets of depression as perceived, experienced and expressed by self-identified depressed men. A unitary model of men with depression began to emerge (see Figure 1).



**Figure 1. Mutual Manifestation of Life Patterning for Male Depression**

The model is open to and completely one with the environment. The center core; perception, expression, and experience is one entity. The lines in the diagram are only for graphic integration. These three elements of human essence are contiguous and can only be wholly appreciated and understood as an all-embracing energy system. The visible manifestations of patterning spiral around the center core in representation of a continuously changing and expanding coil.

The aspects are presented in a messy and non-chronological order representing Roger's understanding that time is a faulty concept and that man's life continues along a "spiraling longitudinal axis" (Rogers, 1970, p. 100). At different life junctures different issues either emerge prominently or recede into the background. Even as life spirals towards increasing complexity in a probabilistic and non-repetitive manner, each revolution does experience similarities. In the man, the boy resides. When the men in this research project shared their stories they re-examined some boyhood events and used them to provide depth and meaning and to increase their own understanding of their depression. The luminous environment fills the spaces between coils and supports the spiral as it floats in a pan-dimensional space. The man cannot help but be influenced by the environment with which he is integrally linked. This model captures the human capacity to actively engage in reflection, utilize knowledge for empowerment, and participate in pattern formation.

## **CHAPTER V**

### **DISCUSSION**

#### **Contributions to Science**

This study uncovered themes which supported existing knowledge about men and depression. Although it was not a primary goal of this research; the coincidental confirmation of prior research strengthened the credibility of previous findings. For truer understandings of human experiences to be solidified, previous findings must be retested in many formats and produce similar results. Polit and Beck (2004) wrote that a strong evidence based practice requires replication of research results. Repeated emergence of consistent findings about men and depression offered “special advantages in both establishing the credibility of research findings and extending their generalizability” (p. 233). Likewise, an existing body of knowledge which supported results from the current research strengthened these results.

Men in this study cited physical abuse, sexual abuse, emotionally remote parents, physical pain, rejection, low self-esteem, early onset anxiety, trauma, and family histories of depression. Most of these pre-cursors to male depression were identified by Kendler et al. (2006). Men sought reassurance and confirmation that they were okay. They went over their lives and valued traits and activities that proved to them, that in spite of having depression, they were normal guys. This need to “reconstruct a valued sense of themselves and their own masculinity” was identified by Emslie et al. (2006, p. 2255), as

an important step towards healing for men living with depression. Previous studies found that men tended to delay entry into treatment, because they wanted to fix the problem themselves and maintain their own sense of competency. That was also true for this sample of men.

New information emerged in the current study which added meaning to the body of knowledge about men and depression. New information included a sample of depressed men not previously identified by researchers, how men live with depression, men's understanding of depression, and where men seek treatment. Men talked about the profound effect depression had on their lives. Rogers (1970, p. 83) wrote "Science is concerned with meaning rather than with facts" (p. 83). Men reflected back on how living with depression had clouded life events. They understood their depression as related to earlier life experiences. Even though no interview questions directly asked about childhood experiences; these men overwhelmingly reached back into their childhoods for the seeds of their depression.

The sample of men in this study was unique in that each man self-identified himself as having a personal story to tell about depression. In prior research, sampling methods relied on inclusion in a group. Researchers interviewed men in active treatment at clinics, hospitals, and rehabilitation settings. Other studies have used focus groups to obtain a public opinion about men and depression. Research has been conducted with psychology students, military inductees, or men associated with other groups, for instance policemen, teachers, or firemen.

The sample was important for this study because it brought forth testimonies from men who would be outside the normal range of many clinical studies. It provided a view into how men with a history of depression perceived, experienced, and expressed their depression whether or not they had been diagnosed as depressed by a clinician. The study provided some insight into the hidden epidemic of men with depression. This is exactly the target sample I had hoped to access in my exploration of men and depression. I wanted to explore how a man could go from being highly functional to desperate and possibly suicidal without presenting clues about internal strife. The results of this study began to shed light on depressed men before they hit the proverbial wall or went through a critical event which created awareness that they really were depressed and really did need help.

Men in this study talked about living with long term depression. Information from these interviews suggested men not only delayed entry into treatment, rather they lived for years with an underlying depression that affected all aspects of their being. Depression was a constant grinding companion which interfered with their social, academic, and career successes. It dampened interpersonal relationships. Several men additionally endured episodes of major depression. All of these men talked about how they actively dealt with depression. Many decided to learn more about psychology and depression through classes and the internet. Some had been to a counselor. Five of them were on medications to manage symptoms and they all said they needed to continue the medications. None of the men talked about ever being depression free and not needing

medication. They had accepted it as a problem to be dealt with and developed ways to cope.

The way men understand depression has been related to being in denial about depression. The concept of denial has various uses in medical and psychiatric practice. The classic Freudian denial is a defense mechanism. It functions as a protective process, “Denial avoids becoming aware of some painful aspect of reality” (Meissner, 1985, p. 389). Denial occurs at an unconscious level when something in life is extremely disturbing or threatening to the individual. The psyche keeps the event out of the conscious mind. When a medical practitioner dictates a patient’s history and physical he or she uses the word “denial” to rule out the presence of symptoms; as in “denies shortness of breath” or “denies suicidal ideation.” When substance abuse counselors use the word denial; they mean a person is falsifying the truth. The person denies he has a drinking problem when he has visible evidence that it is impacting his work and family life.

The classic interpretation of denial would suggest that depression is such an intense threat to the male ego that it is clamped down upon at an unconscious level and never enters awareness. The substance abuse concept of denial suggests that the man understands depression, can identify his own symptomatic markers and daily experiences depressed feelings but continues to ignore them. The use of denial implies that men then reject the facts of their condition and actively cast off any personal association with depression. Men in this study presented a different picture of men with depression. Most of them lacked knowledge of their depression. They said they could not

see it when they were in the midst of a major depressive episode. They thought their feelings were a normal part of life; they said everyone has down times and problems. They needed a trusted spouse, medical provider, or cardinal event to make them truly aware of their depression.

It was not a matter of saying nothing was wrong; these men were aware they had a problem, something was not right. These men often did try to fix the problem. The problem became primary and blocked visibility of a larger depression and opportunities for help. Several men stated that they really were unaware of being depressed during the very worst times. They were able to understand later that they had come through major depression.

Men did not have a name for what was wrong. Most of the men actually felt relief when someone they trusted told them they had depression. That did put a name on their problem and things began to make sense to them. The name depression gave them something to work with. They could educate themselves about it. There were things they could do about depression; they could get counseling and take medication. Men in this study could understand the working mechanisms of the medication. Further when a supportive person finally said to them that they had depression, the men felt that someone understood how badly they felt. When the depression was named, and its existence validated, men were willing to get help.

Men in this study overwhelmingly sought help from their general practitioner/family doctor, (GP). A distinction is meant to be made here between the general practitioner/family doctor and a primary care giver. The GP is a medical doctor.

Primary health providers include physician assistants, nurse practitioners, county health clinics, internists, gynecologist, etc. Although the men may have eventually gone to a mental health provider for counseling; for most of them their first attempts at getting help was with their general practitioner. They also continued their treatment and medication management with their GP after counseling ended. Men in this study had long term trusting relationships with their GP. Men were willing to listen when the GP introduced the word depression during the consultation, advised counseling, and initiated antidepressant medications.

That men contact their general practitioners first for all medical care may be a function of the modern US health care complex. In some parts of US today, it is possible for a healthy woman to rarely encounter a general practitioner as her primary health care provider. A woman may be treated at the pediatrician's office until early adulthood. She may get birth control services at a clinic, and spend her reproductive and many of her adult years under the care of a gynecologist. In her middle years she may choose an internist and later transition to care from a gerontologist. Women may be much more comfortable segmenting their health care needs by specialty. They may be more comfortable with using a medical specialist for preventative services or active treatment. Women may be less likely to interpret specialty service providers as an indication that something is seriously wrong. Therefore, when women begin to experience emotional distress, it may be easier for them to consult a mental health professional.

Men expressed feeling comfortable getting help for their problems, which they called increased stress or anxiety, from their family doctor. It would have been much

more difficult for them accept treatment from a psychiatrist. Psychiatric care would mean they had really crossed some line from being stressed to being someone who was mentally ill, maybe even crazy. It would have meant that there was really something seriously wrong with them. Men who accessed the mental health system first did so after some personal crises, for example, an encounter with the law or suicidal ideation which resulted in emergency intervention. Men in this sample may represent a previously unknown population of men who have been managing depression outside of the normal mental health system. These men might not have been counted in statistics showing the rate of depressed men in general or in relation to the number of depressed women. It also raises the question about what happened to depressed men who do not have a long term trusting relationship with a primary care provider. When and where do they seek help for depression?

### **Contributions to Theory**

In the science of unitary human beings Rogers (1986) wrote that the word nursing was a verb when it was used to describe the art of nursing practiced in the delivery of patient care. Results from this study could be used by nurses to enhance their work with men. An important theme identified was that a man needs his health care provider to really listen to him. Men need to trust their provider and believe they are being heard. Nurses need to take as much time as possible to listen to his story and to read between the lines of the spoken words. Men may not use the word depression; but they will be trying to express their suffering. Men may not have an awareness of depression as classified in a medical textbook. In today's pressurized health care environment the

tendency is to go through a check list of symptoms or use a standardized screening tool to make a diagnosis and then write a prescription. When men arrive for health care they tend to use different words to describe depression. If the provider asks the wrong questions based on those words; the depression can be missed completely.

Rogers's theory of the science of unitary human beings came alive as these men told their stories. Rogers set her theory in a pan-dimensional reality. To me this means that life surrounds us; many events occur simultaneously within the human/environmental energy field. We are not necessarily conscious of all these events and yet they may have an effect upon us. Likewise our individual actions affect our energy fields. This pan-dimensional reality is non-linear, has open energy exchanges, and is not defined by temporal or spatial measures. Events in this reality are non-causal and non-repetitive.

Rogers developed three principles of homeodynamics with the intention of describing the nature and direction of human change. The principle of resonancy postulates the “continuous change from lower to higher frequency wave patterns in human and environmental fields” (Rogers, 1992, p. 31). Men in this study shared stories about their lives beginning in childhood until the current time. As they talked one could observe that their lives had begun with the lower and slower frequency wave patterns of childhood and progressed to the more hectic and multifaceted higher and faster frequency wave patterns of adulthood. The men moved from the smaller world of family of origin out to a complex world with schools, careers, new families, and multiple responsibilities. They shared how they perceived depression had impacted this life journey. They began

their story wherever they felt comfortable and moved about in a non-linear manor from one event to another. The facets of each story became synthesized into a holistic patterning manifestation representing their encounters with depression. As the each man revealed facets of himself related to depression he revealed the unified representation of his patterning profile.

The principle of helicity demonstrated, the “continuous, innovative, probabilistic increasing diversity of human and environmental field patterns characterized by non-repeating rhythmicities” (Rogers, 1992, p. 31). Helicity occurred along a spiraling longitudinal axis and although events do not repeat, similarities were present. Helicity is the principle which contains cognition and feeling; in it “predictive potential exists for a wide range of events in the real world” (Rogers, 1970, p. 100). Men in the study demonstrated the presence of helicity in their lives. As they reflected on their lives with depression they reviewed events throughout their lives. They identified similarities along the way, perhaps episodes of recurrent depression or a family history of depression. This process helped them to develop a deeper understanding of their own perceptions, experiences, and expressions surrounding their depression. Helicity also demonstrates that we cannot hope to truly understand a man if we separate his experiences into parts or examine them out of context. We cannot understand what depression is like for men if we only ask questions about the symptoms of depression, in the present tense, like mood, appetite, and sleep patterns. Freud told people in analysis that they did not have to just speak about the present. They could talk about the past or the present because “it was all useful and of one piece” (Wortis, 1954, p. 71). Rogers (1970) agreed “The life process is

a constantly evolving series of changes in which the past has been incorporated and out of which new patterns have emerged” (p. 98). This understanding does not support the concept of a cause followed by an effect; rather the inclusion and reorganization of meanings. Rogers also postulated that when we view any facet of a person, we are really viewing a patterning of the whole person. This concept was demonstrated during the research interviews as men told their stories about earlier life experiences that had contributed to them being the men they were today. Life is a continuous process; it constantly changes and yet maintains the integrity of uniqueness and wholeness.

The third principle of homeodynamics postulated that integrality was the “Continuous mutual human field and environmental field process” (Rogers, 1992, p. 31). We cannot understand a man and his depression if we separate him from his environmental energy field. Human and environmental fields evolved together. They were integral, essential to and undivided from one another. The men in this study always talked about their depression in relation to their world made up on their families and their work. Rogers (1970) wrote that “human relationships as instruments of therapy are increasingly emphasized” (p. 122). Depression served as a permeable membrane between each man and his environment. Men were in constant communication with their environments. They interacted with their environments giving and receiving feedback. Men and their environments responded to healthy and dysfunctional changes in one another. Certainly each man had his own unique story about depression and how it had impacted his personal life and relationships with others, but each one demonstrated that he was integral with his own environmental energy field. For each man the environmental

field was important and contained valued assets. He may have felt alone or isolated but he was never truly cut off from his environmental energy field.

In the middle range theory, unitary appreciate participatory inquiry; Cowling explicated a method for incorporating concepts from Rogers's theory into a total model for nursing. He directly merged theory, research, and practice into praxis. Praxis gave nurses a direct link from research to delivery of patient care. In the research model, participants were viewed as the experts of their own experience and co-researchers in the process of knowledge development. This presented the opportunity for a more open research style. It created a better way to explore what really occurred for a patient. It created space for research questions to reach beyond questions fixed by a researcher and limited to what the researcher identified as important. For this study a list of open ended questions was created; but very often failed to provide useful information. Men just told their stories. The actual data collected was much richer and deeper than could have been obtained by probing questions. Men talked about issues they identified as important. For instance, there were no questions about family, jobs, or childhood, yet each man talked extensively about them. Each one talked about how his depression had impacted the different areas.

Another concept in Cowling's model is research itself can become a therapeutic and empowering process. Men in this study demonstrated both of these processes. They said the interview had indeed been therapeutic; it had helped them reflect, reorder, and understand the sequence of events and how interrelated they were. Deeper understanding was not possible while they were in the midst of depression. The men had initiated

participation in the project and through the process they felt empowered. They wanted to use their experience to help other men. They also used it as a part of their own healing.

Cowling (2001) introduced the concept of appreciative knowing. It is the idea that life is ultimately a miracle and a mystery that can never be fully understood. In this arena one admits that depression in men can never be accurately and completely represented. However by using a research method like unitary appreciate participatory inquiry the researcher and the participant become equal inquirer-participants which allows for exploration beyond the normal range of questioning and creates a more profound data base. Cowling (2001) said that this intense level of exploration depends on “the willingness of parties involved to come together freely and openly” (p. 34). Indeed, a very mystical part of this study was that at the needed time these men appeared to share their stories. Cowling set forth the premise that with UAPI inquirer-participants are not alienated from their world but become involved in life, they engage in “participatory consciousness, whereby there is a personal stake or partnership with the universe” (p. 34). Almost the first thing each man in this study said was that he was doing it to help other men with depression. Each man took a risk to venture outside of his own isolation and contribute to a more universal understanding of men and depression.

### **Contributions to Nursing**

Rogers (1986) wrote the word nursing was a noun when it was perceived as a scientific body of knowledge. A scientific body of nursing knowledge embedded with nursing theory contributes to continuing and strengthening nursing as a distinct discipline. The current study was designed to contribute to the existing body of nursing

knowledge about the phenomenon central to nursing's purpose, "human beings and their world" (Rogers, 1986, p. 3); specifically men with depression. Nursing theories were used to explore depression in men from a unitary holistic view. The abstract conceptual frameworks in Rogers's theory, the science of unitary human beings, and Cowling's unitary appreciative participatory inquiry model support this work. Incorporating these theories into nurse led research about men and depression can serve to make them more valuable for practicing nurses.

Many nurses have not valued nursing theory; they have had difficulty understanding what purpose it serves in their daily practice. They have felt that nursing theory was intangible or did not represent a realistic view of nursing. As nurses see more nursing based research studies addressing their own area of practice which are grounded in nursing theories and incorporating nursing research models, they will become more comfortable with its value. Nurses will have increased appreciation when they comprehend that nursing theory based research enriches their practice. Nursing research acknowledges phenomenon nurses have long been cognizant of but which have seemed elusive. Nursing research directly addresses issues in patient care. Although nursing borrows from many other disciplines, medicine, psychology, and sociology for intervention techniques; it remains important for nurses to be centered the nursing discipline. As nurses provide patient care they should turn to their own scholars and frame their care based upon nursing theory. Nursing care begins with appreciating the wholeness of each person and designing care which best fits with that unique human being. It means viewing health and illness as "expressions of the process of life" (Rogers,

1970, p. 85). It means seeking ways “to assist people in achieving their maximum health potential” (Rogers, 1970, p. 87).

Nurses who base their practice on nursing theories will have a better understanding of the unique contribution they make in health care. Nurses with a strong theoretical base will experience more satisfaction in their work and will be more resistant to burn out. Basing nursing care on Rogers’s grand theory (Fawcett, 1999) and Cowling’s middle range theory (Repede, 2007) expands possibilities in providing care. Treatment is provided within a holistic context addressing patient needs within a comprehensive framework. Theoretical frameworks encourage nurses to appreciate the unique whole person in relation with his environment. Nurses are encouraged to look beyond the pathology to the human being. Meaningful interactions with the human beings are what feed the soul of nursing.

### **Limitations of the Study**

One limitation of this study was the small sample size. Only six men came forward to participate and share their stories. The size of the sample alone would make it difficult to generalize results to a larger population of men. However, many of the topics identified by men in this study supported information uncovered in prior and larger studies about men and depression. Congruence with previous larger studies increased the likelihood that the current results could be generalized to a larger group of men. It also indicated that I truly accessed a sample of depressed men. This occurred even though men self-identified for participation, chose topics to share, and were not previously referred by mental health professionals as diagnosed with depression. Unique to this

study were the small sample size and open design that allowed an in-depth exploration of the perceptions, experiences, and expressions behind numbers and variables previously identified. By devoting intense energy and focusing of a small number of participants rich meaningful data was obtained. The data illuminated details that through the process of syntheses merged to reflect a more holistic representation of men with depression.

A second limitation of the study was the overall homogeneity of the sample. Some of this was constructed into the study with intent to include adult males in their most productive years who somehow had encountered depression. The goal was to control for extraneous variables like physical illness, grief, major mental illness, and primary substance abuse. The result was that six white males participated. One man was Latino/white. The study was designed to allow for and appreciate the uniqueness of each man's story, so even though the sample was homogenous the stories may have presented enough differences to encompass a more universal male population. Perhaps future studies could focus on men with depression from different age groups, races, or cultures.

### **Conclusions**

There are as many perceptions, experiences, and expressions of depression as there are men with depression. Each man in this study had his unique story about depression. In order to understand how a man engages with depression one should appreciate the wholeness of his story. This expanded vista would uncover more depression in men. With the current diagnostic medical models men who do not precisely meet the criteria for depression are often misdiagnosed. This study supported the possibility that more men suffered from depression than ever entered into formal mental

health care. These men don't get help with depression; nor are they represented in the statistics showing the number of men who are depressed. Perhaps it is too late by the time men meet criteria for clinical depression. A valuable contribution of this study is that it included men who self-identified as depressed and not necessarily men who were diagnosed with depression by a mental health profession. One finding of this study would be to encourage general practitioners/medical doctors to be more vigilant in assessing and treating depression in men.

The men in this study were not defensive when they admitted they really did not grasp the concept of men having depression. Depression was seen as something women were involved with like child birth. Depression in men was simply a foreign concept; yet each man lived with an inner knowledge that something was not right in his life and he struggled to manage daily. Each man related a long history of depression and many identified roots in his childhood.

This work fulfilled the three specific aims which were proposed for exploration in this study. It provided the opportunity to illuminate the life patterning of wholeness associated with depression, as perceived, experienced, and expressed in men. The study contributed to unitary nursing knowledge about men's experience of depression and health. The study utilized Rogers' theory of unitary human being and Cowling's unitary appreciative inquiry methodology as an approach for nurses to develop a distinctive body of nursing knowledge.

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## **APPENDIX A**

### **INTERVIEW QUESTIONS**

1. Describe for me what it is like when you feel depressed.
2. What is depression like exactly? If you had to list its features, what are they? How do you express your depression? Some men use anger, some alcohol?
3. Is there a story, a poem, or a picture that conveys what your depression is like?
4. Describe how your life is different when you are depressed compared with when you are not depressed?
5. Do you think depression has transformed you? If yes, in what way has depression transformed you? What have you not been able to do because of depression?
6. What would create the best picture of your depression to help me understand your depression?
7. Has there been any treatment or remedy that you have used to help you through depression? Did you use anything outside of normal treatments?
8. If yes, could you tell me what they are and how they helped you?
9. What experiences have you had with health care providers (nurses, doctors, or anyone in the health care system) that relate to your depression?
10. Has anyone done anything that was useful to you in dealing with your depression?
11. Has anyone done anything that was not useful?
12. Did you find help when you used the health care system?
13. Other names for depression? Are there other ways you would talk about depression?

**APPENDIX B**  
**NEWSPAPER ADVERTISEMENT**

**DEPRESSION & MY LIFE:  
A MAN'S PERSPECTIVE – SHARE YOUR STORY  
A RESEARCH STUDY**

How do men experience depression? I am looking for men 21-60, with depression in the last 5 years, who would like to share a story and can attend 2 sessions in a private office location.

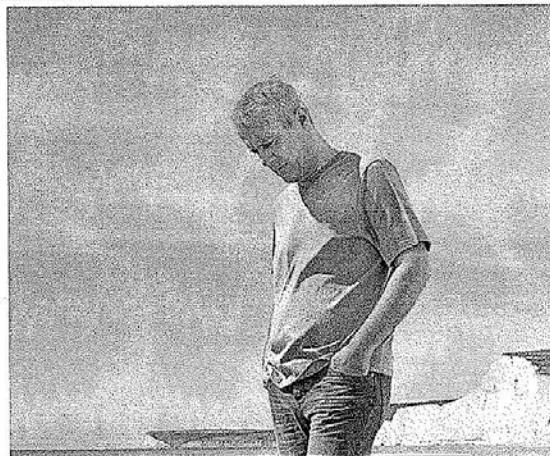
Contact M. Kaufman, RN, APRN, UNCG PhD student at  
**828-315-1177 or m\_kaufma@uncg.edu.**

Time and travel compensation for 2 sessions is \$30.

## APPENDIX C

### RECRUITMENT FLYER

# Depression and My Life: A Man's Perspective



RESEARCH STUDY: How men experience depression. Have you been depressed in the last five years? If you are a man between 21 and 60, read and speak English and would like to share your story, please contact: Millicent Kaufman, RN, APRN, PhD student at the University of North Carolina Greensboro. Daytime: 336-334-3167 Weekends: 828-308-2232 e-mail: [m\\_kauf@uncg.edu](mailto:m_kauf@uncg.edu)

You will be asked to participate in two interviews and read a summary of your interview. The interviews will be done in a private setting at a mutually agreed upon location for the participant and researcher. Your total time commitment may be up to 8 hours. At the end of the research you will be paid \$30.00. Principle investigator, Dr. Richard Cowling, RN, PhD, can be reached at 804-920-0020 or [rcowling@chamberlain.edu](mailto:rcowling@chamberlain.edu).

APPROVED IRB

SEP 19 2011

## **APPENDIX D**

### **PRE-INTERVIEW WORKSHEET**

#### **Pre-screening questions:**

Do you have a personal story about depression?  
Are you interested in sharing your story? Are you interested in participation as a co-researcher in a study about men and depression? This will include more than one session.  
Are you between the ages of 21 and 60?  
Will you have transportation to and from the interview?  
Are you able to read, to write, and to speak English?  
Are you currently feeling acutely depressed or suicidal?  
Are you currently in treatment for any medical condition?  
Do you have other mental health issues such as schizophrenia, bipolar illness, alcohol or substance abuse?  
Have you experienced the death of a loved one in the last year?

#### **Pre-interview information:**

This research project is seeking answers to the questions:  
What do men think about their own experiences of depression?  
How did you know when you were depressed and what did you tell yourself about depression?  
How do men act when they are living with depression?  
What happens when men seek relief from depression? Where do they go? What remedies do they try?  
Please bring a picture identification card to the interview. To verify your age.  
You will be asked to sign a voluntary consent form before the interview begins.  
It is acceptable for you to bring articles to the interview that will help to tell your story, for example, photographs, books, a drawing or journal.

Participant's name \_\_\_\_\_ Chosen pseudonym \_\_\_\_\_

Contact Telephone Number \_\_\_\_\_

Preferred time to get calls \_\_\_\_\_

E-mail address \_\_\_\_\_

Appointment date \_\_\_\_\_ time \_\_\_\_\_

Location\_\_\_\_\_

## APPENDIX E

### CONSENT FORM

**UNIVERSITY OF NORTH CAROLINA AT GREENSBORO**

#### ***CONSENT TO ACT AS A HUMAN PARTICIPANT***

Project Title: Life Patterning of Men with Depression

Project Director: W. Richard Cowling, III

Participant's Name: \_\_\_\_\_

**What is the study about?**

This is a research project being conducted as part of a doctoral education program. The focus of the research is to explore what it is like for men who have experienced depression in their lives. Men are being asked to share their personal memories, thoughts, and feelings about what depression was like for them. Individual histories will be examined to create a profile of what the experience was like in the lives of each man interviewed. The individual profiles will be examined to see if there are commonalities in the way men experience depression in their lives.

**Why are you asking me?**

You are being asked to participate voluntarily to share your story about your depression. The best source of knowledge about men and depression will result by interviewing men who have experienced depression.

**What will you ask me to do if I agree to be in the study?**

The research project will involve a face to face interview where the researcher will ask questions. The first interview may last up to two hours. After this meeting I will use the information to create a descriptive individual profile that summarizes your experience. I will give the profile to you for your review, reflection, and approval. We will meet a second time to discuss your impression of the profile, change it based on your input, and answer any questions you might have. All interviews will be conducted in a setting that assures privacy and is convenient to participants. Your total time commitment may be up to 8 hours.

**Are there any audio/video recording?**

All sessions will be audio recorded. Two recorders will be used to protect against equipment failure and outside noises that might affect the recording. Because your voice will be potentially identifiable by anyone who hears it, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will limit access to the tape as described below.

**What are the dangers to me?**

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. Entry in the study is voluntary and provides for conditions of withdrawal at the request of the participant. Discussion of depression may stimulate some feelings of emotional distress. If this should occur and you wish to withdraw from the study, you may do so at any time. The student researcher and faculty involved in the project are both nursing specialists in mental health and will be observing for any signs of distress and provide a list of some possible resources for you to minimize your distress.

UNCG IRB  
Approved Consent Form

Valid 9/9/16 9/17/12

If you have any concerns about your rights, how you are being treated or if you have questions, want more information or have suggestions, please contact Eric Allen in the Office of Research Compliance at UNCG at (336) 256-1482. Questions, concerns or complaints about this project or benefits or risks associated with being in this study can be answered by W. Richard Cowling, III the principal investigator, who may be contacted at (804) 920-0020 or by email rcowling @chamberlain.edu.

**Are there any benefits to me for taking part in this research study?**

There are no direct benefits to individuals participating in this research study. Participants may benefit from the opportunity to share their story about depression and be heard. They may experience new understandings about their experience and feel a sense of empowerment. Each person involved will be offered access to the final report which may enhance their understanding of how their experience is similar to the experience of other men.

**Are there any benefits to society as a result of me taking part in this research?**

The results of this study may have a positive impact in the future of identifying and treating depression in men. The results of this study may provide new insights and knowledge about men and depression which could help people in the health field improve how they identify and treat depression in men. Results may contribute to providing men with permission and easier access into treatment.

**Will I get paid for being in the study? Will it cost me anything?**

There will be no cost to you for participating in the research project. At the end of the second meeting participants will receive thirty dollars to help cover transportation costs.

**How will you keep my information confidential?**

All information obtained in this study is strictly confidential unless disclosure is required by law. All typed documents and computer jump drives will be stored in locked file cabinet in the student researcher's home. Computers and jump drives used to create and store documents will be password protected. Each participant will be asked to provide a code name for himself. Thereafter all stored files and documentation will use his code name.

**What if I want to leave the study?**

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state.

**What about new information/changes in the study?** If important new information relating to the study becomes available which may relate to your willingness to continue to be a part of the study, this information will be given to you.

**Voluntary Consent by Participant:**

Millicent Kaufman has explained the procedures involved in this research project including the purpose and what will be required from you. I have been given an opportunity to ask questions about my participation in this project. By signing this consent form you are agreeing that you have read it, or that it has been read to you and you fully understand the contents of this document and are openly willing to consent to take part in this study. All of your questions concerning this study have been answered. By signing this form, you are agreeing that you are 20 years of age or older and are agreeing to participate.

I was given the opportunity to ask my questions about this research. Initial \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

UNCG IRB  
Approved Consent Form

Valid 9/9/11 to 9/17/12

**APPENDIX F**  
**DEMOGRAPHIC DATA FORM**

PLEASE CIRCLE ONE ANSWER THAT BEST DESCRIBES WHO YOU ARE

RACE: BLACK      WHITE      ASIAN NATIVE AMERICAN

HAWAIIAN/PACIFIC ISLANDER      MIXED RACE

ETHNICITY: LATINO      NON-LATINO

PRIMARY SPOKEN LANGUAGE:      ENGLISH      SPANISH      OTHER

PRIMARY WRITTEN LANGUAGE:      ENGLISH      SPANISH      OTHER

AGE: 21-31  32-41  42-51  52-60

HOUSEHOLD INCOME:      LESS THAN \$10,000

11,000 TO 19,999

20,000 TO 29,999

30,000 TO 49,999

50,000 TO 100,000

NUMBER OF PEOPLE LIVING IN THE HOME: 1\_\_\_\_  2-5\_\_\_\_

6-10\_\_\_\_  10 or more

MARITAL STATUS:      MARRIED      DIVORCED      SINGLE

*NUMBER OF VISITS TO A HEALTH CARE PROVIDER IN THE LAST YEAR:*

NONE      1      2-5      6-10      12      13 or more

*WHERE DO YOU GET YOUR HEALTH CARE SERVICES?*

MY DOCTOR      THE CLINIC      THE EMERGENCY ROOM

OTHER SOURCE OF HEALTH CARE

WHAT WAS THE PRIMARY REASON FOR THE VISITS?

**HIGHEST EDUCATION ACHIEVEMENT:**

8<sup>th</sup> grade or less

Less than high school

High School degree

Associates Degree

4 year College Degree

More than a 4 year College Degree

**DEPRESSION:** Number of times depression has impacted your life:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 or more \_\_\_\_\_

Length of episodes

Currently Depressed?

***HAVE YOU HAD TREATMENT FOR DEPRESSION?***

***IF SO, WHEN?***

***WHAT TYPE OF PROVIDER?***

***WHAT TYPE OF TREATMENT?***

***MEDICATION***

TALK THERAPY

INDIVIDUAL

GROUP

**APPENDIX G**  
**DATA ORGANIZATION FORM**

Initial telephone contact:

Appointment:

Signed consent:

Demographic survey:

Interview:

Set time for follow up appointment:

PI: Field notes

Transcription:

PI review:

Annotations

Memos

Correction to transcript:

Second Appointment:

## APPENDIX H

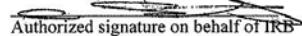
### INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL



**OFFICE OF RESEARCH COMPLIANCE**  
2718 Beverly Cooper Moore and Irene Mitchell Moore  
Humanities and Research Administration Bldg.  
PO Box 26170  
Greensboro, NC 27402-6170  
336.256.1482  
Web site: [www.uncg.edu/orc](http://www.uncg.edu/orc)  
Federalwide Assurance (FWA) #216

**To:** William Cowling  
Research, School Of Nursing, Office Of

**From:** UNCG IRB

  
Authorized signature on behalf of IRB

**Approval Date:** 9/19/2011

**Expiration Date of Approval:** 9/17/2012

**RE:** Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)

**Submission Type:** Initial

**Expedited Category:** 7.Surveys/interviews/focus groups,6.Voice/image research recordings

**Study #:** 11-0296

**Study Title:** Life Patterning of Men with Depression

This submission has been approved by the IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

**Study Description:**

The purpose of this project is to study the lives of men who are living with depression to ascertain the factors and forces that contribute to how they experience and process this experience in their lives.

**Investigator's Responsibilities**

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. These consent forms must be used unless the IRB has given you approval to waive this requirement.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the modification application available at <http://www.uncg.edu/orc/irb.htm>). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the "Unanticipated Problem/Event" form at the same website.

**CC:**

Millicent Kaufman

Chris Farrior, (ORED), Non-IRB Review Contact  
, (ORC), Non-IRB Review Contact



THE UNIVERSITY of NORTH CAROLINA  
**GREENSBORO**

**OFFICE OF RESEARCH COMPLIANCE**  
2718 Beverly Cooper Moore and Irene Mitchell Moore  
Humanities and Research Administration Bldg.  
PO Box 26170  
Greensboro, NC 27402-6170  
336.256.1482  
Web site: [www.uncg.edu/orc](http://www.uncg.edu/orc)  
Federalwide Assurance (FWA) #216

**To:** William Cowling  
Research, School Of Nursing, Office Of

**From:** UNCG IRB

  
\_\_\_\_\_  
Authorized signature on behalf of IRB

**Approval Date:** 9/17/2012

**Expiration Date of Approval:** 9/16/2013

**RE:** Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)

**Submission Type:** Renewal

**Expedited Category:** 7.Surveys/interviews/focus groups,6.Voice/image research recordings

**Study #:** 11-0296

**Study Title:** Life Patterning of Men with Depression

This submission has been approved by the IRB for the period indicated.

**Study Description:**

The purpose of this project is to study the lives of men who are living with depression to ascertain the factors and forces that contribute to how they experience and process this experience in their lives.

**Submission Description:**

Renewal request, dated 9/17/12. Participant involvement complete, renewal requested for data analysis only.

**Regulatory and other findings:**

- This research is closed to enrollment and remains open for data analysis only.

**Investigator's Responsibilities**

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be

scanned to you in a separate email. These consent forms must be used unless the IRB has given you approval to waive this requirement.

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CC:  
Millicent Kaufman  
ORC, (ORC), Non-IRB Review Contact

## **APPENDIX I**

### **REFERRAL SOURCES**

#### **Hospitals**

Catawba Valley Medical Center

82-326-3000 Main Number

Frye Regional Medical Center

828-315-5000 Main Number

828-315-5719 Mental Health

#### **Outpatient Services**

Catawba County Mental Health                            327-2595

Family Guidance Center                                    322-1400

Mental Health Partners (available 24/7/365)                            1-877-327-2593

#### **National Organizations**

Depression and Bipolar Support Alliance (DBSA)

(800)-826-3632

[www.DBSAAlliance.org](http://www.DBSAAlliance.org)

National Alliance on Mental Illness (NAMI)

800-950-6264

[www.nami.org](http://www.nami.org)