
Men's discourses of help-seeking in the context of depression

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Abstract Depression is an illness increasingly constructed as a gendered mood disorder and consequently diagnosed in women more than men. The diagnostic criteria used for its assessment often perpetrate and reproduce gender stereotypes. The stigma associated with mental illness and the gendered elements of depression suggest there are likely numerous discourses that position, explain, and justify help-seeking practices. This qualitative study explored men's discourses of seeking help for depression. The methodological approach was informed by a social constructionist perspective of language, discourse and gender that drew on methods from discourse analysis. We conducted individual in-depth, semi-structured interviews with 38 men with depression, either formally diagnosed or self reported. The analysis revealed five discursive frames that influenced the men's talk about help-seeking and depression: manly self-reliance; treatment-seeking as responsible independent action; guarded vulnerability; desperation; and genuine connection. The findings are discussed within a broader context of social discourses of gender, the limitations of current help-seeking literature and the evidence for how men seek help in ways that extend traditional notions of medical treatment.

Keywords: masculinities, depression, help-seeking, discourse, qualitative

Introduction

Depression, largely constructed as a gendered mood disorder, is diagnosed in women more than in men. In 2008, 5 per cent of Canadian-based men compared with 8.2 per cent of women were diagnosed with a mood disorder (Statistics Canada 2008). Although men are conspicuously absent in the psychiatric history related to the development of the category and diagnosis of depression, this bias has been normalised in the medical literature throughout the 20th century (Hirshbein 2006). For example, Hirshbein (2006) argues that the approach to clinical trials for antidepressant medications focused largely on women and the development of depression classifications in the *Diagnostic and Statistical Manual of Mental Disorders* contributed to the construction of depression as a women's mental illness. For decades health professionals and lay persons viewed depression as a negative state associated with women, in which symptoms such as tearfulness were synonymous for depression in

women (Bengs *et al.* 2008). Professional health discourses tend to ignore gender differences in the symptom expression of depression to such an extent that some researchers have declared the medical system to be gender blind, pointing out that diagnostic criteria for depression are genderless, with the potential to perpetrate and reproduce gender stereotypes (Johansson *et al.* 2009, Johnson and Stewart 2010).

Depression, men and masculinity

The social construction of gender influences men's health, wellbeing and interactions with the healthcare system. Since Courtenay (2000) adapted Connell's (1995) masculinities framework to the field of men's health, a small body of empirical work has emerged to describe how gender and constructs of masculinity contribute to the perceived prevalence and manifestation of depression among men. A study of male university students experiencing depression revealed how traditional masculinity continues to inform many young men's depression-related self-care practices (OliFFE *et al.* 2010a). The ways in which men embody depression in their everyday lives (such as anger, isolation and autonomy around self-management practices, and risky self-care practices such as alcohol and drug use) may lead to symptoms of depression being interpreted as expressions of masculine ideals (OliFFE *et al.* 2010b). Galasiński (2008) argued that the dominant discursive frames in the talk of men he interviewed were rooted in removing depression from any association with the masculine self and avoiding the stigma of mental illness.

Researchers have contested the extent to which gender stereotypes mediate men's experience of depression. A qualitative study of men with depression concluded that pressures to conform to hegemonic masculine ideals contributed to depression but some masculine ideals, including self-control, also aid recovery through fostering a positive sense of self (Emslie *et al.* 2006). The authors cautioned healthcare providers against relying heavily on dominant constructions of masculinity in treating men with depression, because not all men identify with hegemonic masculinity or find associated strength-based strategies helpful.

In general, men may not experience depression differently from women; however, they appear to express depression differently, leading researchers to hypothesise that men who suppress emotion in response to dominant masculine ideals (for example, to avoid being perceived as weak and vulnerable) may also report depression at lower rates and avoid seeking help (Brownhill *et al.* 2005).

Men, masculinity, depression and discourses of help-seeking

Men's perspectives on depression are not developed in isolation; they are influenced by broader societal discourses that inform experiences and decisions. In addition, men's health behaviours, such as help-seeking, are practices that contribute to the active construction of their gendered identities (Courtenay 2000). Because of the stigma associated with men's depression (Galasiński 2008, Johansson *et al.* 2009) and the gendered elements of depression, there are likely to be distinct social discourses that position, explain and justify men's help-seeking practices.

A discourse analysis of masculinity and health using focus groups with men to explore their help-seeking patterns concluded that seeking help challenged men's masculine identities (O'Brien *et al.* 2005). The authors argued that a dominant discourse of hegemonic masculinity 'is one in which help-seeking is only contemplated following pain, endurance,

stoicism and visible injury' (O'Brien *et al.* 2005: 514). Discussions of depression posed such specific challenges to the men in their study, the men referred to depression as stress, a term the authors claimed was more acceptable to the men's masculine identities. Although some groups of men in their study (such as firefighters) sought out health care, this occurred in situations in which the men perceived that these actions enhanced their masculinity.

Researchers investigating men's talk as the site of social discourses of health have observed that men skilfully move between various subject positions to negotiate their masculine identities in situated contexts (Noone and Stephens 2008). Noone and Stephens concluded that men use discursive strategies to explain and justify gendered healthcare utilisation and to generate a masculine position that emphasises that men seldom use health care, in contrast with the feminine position of women as regular users of health care. Noone and Stephens found the men relied on discursive strategies to justify their healthcare access while preserving their masculine identities, portraying themselves as masterful and knowledgeable users of health care. These researchers also referred to a gendered health discourse that located the masculine ideal as a man who displays tolerance to pain, thereby avoiding stereotypical femininity and frequent consultations (Noone and Stephens 2008). In a qualitative study investigating lay understandings of gender differences in health and life expectancy (Emslie and Hunt 2008), male and female participants offered a common explanation that the authors described as 'men's reticence to discuss problems and seek help', which suggests their alignment with a dominant discourse on masculinity and men's help-seeking. Courtenay (2000) positioned men's help-seeking within a social constructionist frame, stating that seeking professional help is a feminine practice, actively constructed by individuals and healthcare institutions. Courtenay argued that when a man refuses to go to a doctor, 'he is simultaneously describing a health practice and situating himself in a masculine arena' (Courtenay, 2000: 1389). One can read Courtenay's meta-synthesis as evidence of a broad social discourse on men's help-seeking: manly men do not go to the doctor.

A discourse analysis of depression and gender in newspaper texts concluded that media discourses perpetuated gender stereotypes of depression by portraying men as silent about their depression and their feelings, as reluctant to seek help and emphasising sudden physical collapse (Bengs *et al.* 2008). In his analyses of men's health discourses in popular media Gough (2006) argued that the established discourse purporting that men do not seek help and are not interested in their own health is so pervasive even male doctors become implicated in this portrayal of the reckless denial of self-care.

Scientific discourses (Foucault 1971), in the form of medical and social science reviews, have widely reported that men utilise the healthcare system far less than women in terms of seeking help for mental health issues, addictions, counselling and medical problems (Addis and Mahalik 2003). Most research reporting patterns of healthcare usage have focused solely on sex differences and neglected the influence of gender as a social construct in men's and women's health practices (Addis and Mahalik 2003, Galdas *et al.* 2005). Research with a gender focus demonstrates how alignment with dominant constructs of masculinity typically delays men's uptake of professional help for mental distress, because help-seeking is perceived as weak (Branney and White 2008, Oliffe and Phillips 2008, Riska 2009). A comprehensive review of the literature on men's distress stated that the dominant narrative in the academic literature is that men are reluctant to seek help and that an institutional discourse related to silence around men's distress assumed that men do not require more support (Ridge *et al.* 2010).

Popular beliefs, stereotypes, media and academic coverage on men's help-seeking behaviour provide evidence of a dominant discourse of men's help-seeking. The purpose of this study was to determine how participants' reproduced or reconstructed the dominant

discourse of men's help-seeking for depression and to determine if there were alternative ways in which they framed their help-seeking.

Methods

This study was part of a research programme aimed at investigating men's experiences of depression. For the findings reported here a qualitative research approach based in a social constructionist perspective of language, discourse and gender that draws on methods from discourse analysis is employed. We understand the concept of discourse in the Foucauldian sense in which discourses are not defined solely by language or linguistic textual interpretations but refer to the social processes by which meanings are produced as an outcome of social, institutional and historical practices, structures and relations of power (Foucault 1971).

Discourses are shaped by broader social structures and social relations thereby defining, constructing and governing topics and subjects. Discourse analysis considers how texts (that is, the interview transcripts) are constructed in terms of social, cultural, political and historical situatedness (Cheek 2004). Specifically, texts convey certain aspects of reality in particular ways: they are a reflection of and in turn constructed by their context. Thus, we viewed the study participants as speakers whose interviews represented individual sites wherein specific discourses related to depression and help-seeking were taken up and which co-existed with other social discourses. Individuals may take up multiple discourses and use them to organise their speech and assign meaning to their own experience. This critical view of the individual assumes that individuals do not select beliefs or language about beliefs in isolation but in communities of social practice, and that the production of discourse in talk is strategic, active and the result of social and power relations (Talja 1999).

Recruitment

The participants were recruited from three sites in British Columbia (BC), Canada: Greater Vancouver ($n = 20$), a metropolitan area of around 2.5 million; Prince George ($n = 10$), a remote urban centre in northern BC with a population of about 77,000 and Kelowna ($n = 8$), a regional city of about 165,000 people in BC's interior. We recruited men who self-identified as experiencing depression because we were interested in including men with and without a formal diagnosis for depression to understand their help-seeking within a broad social constructionist perspective. Recruitment strategies included postcards, brochures and print media advertisements describing the study and inviting men to contact the project director. The eligibility criteria included the ability to speak English and self-identification as depressed or formal diagnosis of depression. Participants were acknowledged with a CA\$30.00 honorarium.

Data collection

This study received approval from the behavioural research ethics board of a western Canadian university and all participants completed a written consent form. Trained researchers (both men and women) conducted individual in-depth, semi-structured interviews that took 60–90 minutes at a mutually convenient time and location, including a university office, the public library and various coffee shops. We advised the participants that the interview was not intended as a form of therapy but an opportunity for researchers to learn about their depression-related experiences, including their experiences with healthcare providers. The participants completed a socioeconomic questionnaire, and the 21-item,

self-report Beck depression inventory – 2nd Edition (BDI-II) to assess the severity of their depression prior to the interview. Because not all of the participants had been formally diagnosed with depression, we used the BDI-II to gain a sense of the intensity of depressive symptoms experienced by the participants. All the participants received a resource sheet of mental health services and the interviewers had specific guidelines for ceasing interviews if the participants became distressed. The interviews were digitally recorded and transcribed verbatim, excluding any identifying information, reviewed for accuracy and labelled with an identifier code.

Data analysis

We mined the interview data for instances in which the participants detailed depression-related help-seeking experiences through formal or informal routes. From this primary parent code, 'help-seeking', we also identified a subset of data that we labelled 'engagement', which directly related to men's experiences with trained healthcare providers. Some entire interviews, the field notes, as well as the coded engagement data, comprised the textual data for this analysis. We next reviewed these texts asking: what are the specific discursive frames that shape the way men talk about help-seeking? What is the nature and tone of the language the men selected to describe their experiences and how does this relate to their perception of gender? To what extent do the men reproduce or resist popularised discourses about masculinities, depression and help-seeking?

The research team reviewed and discussed the data from a critical perspective and identified and assigned discursive frames that shaped the men's talk. The discursive frames were then probed to determine if they differed for those with and without a formal diagnosis and by severity of depression (captured through the BDI scores).

Findings

A total of 38 men aged 24 to 50 years participated in the study, 12 of whom had not been formally diagnosed with depression. The average BDI-II score was 23.8 and scores ranged from 7 to 48. These scores were slightly higher among the participants who had a formal diagnosis of depression. The men's BDI scores were distributed as follows: minimal depression, $n = 6$; mild depression, $n = 9$; moderate depression, $n = 8$; and severe depression, $n = 15$. Of the 12 men who had not been formally diagnosed, three had BDI scores suggestive of minimal depression, one had a score suggestive of mild depression, four had scores suggestive of moderate depression and four had scores suggestive of severe depression. It should also be noted that some of the men we spoke with were recovering from recent bouts with severe depression so their BDI scores did not necessarily reflect the severity of the depressive episodes they had experienced.

While most men without formal diagnoses relied on self-management or informal support, many had attempted to seek professional medical assistance. All of the men made reference to professional help-seeking. Our analysis revealed the nuanced ways in which the men in this study indexed the dominant social discourse on men's help-seeking. Four of the discursive frames are variations on the dominant social discourses of help-seeking. The fifth frame, genuine connection, suggests an alternative account of help-seeking. We identified no patterns across these discursive frames based on the severity of BDI score, formal or informal diagnoses or other variables, such as age and ethnicity. As social discourses, these frames were not mutually exclusive or chronological in nature; participants often generated multiple discursive frames in their interview. We present the five discursive frames that influenced the

men's talk about seeking help for depression: manly self-reliance; treatment-seeking as responsible, independent action; guarded vulnerability; desperation; genuine connection.

Manly self-reliance

In describing their help-seeking for depression many men were strongly influenced by a discourse of self-reliance. This discursive frame is closely aligned with hegemonic masculine ideals including strength, courage and independence. The men invoked manly self-reliance in a number of ways as they tried to position their depression as a minor personal problem that could be handled alone. The notion that manly men do not seek help was a key feature of this discourse. Many men suggested, with acute awareness, that their reluctance to seek help was tied to their sense of masculinity;

R: Do you think that there's anything that would make you go and talk to a professional?

P: No.

R: Has your partner ever suggested it?

P: No.

R: Has your mother ever suggested it?

P: No. I guess that's why people think that I don't need.

R: 'Coz of you. [Laughs]

P: 'Coz of me. It's manly men and me. [Laughs] (24 years, BDI 7) [R = researcher, P = patient]

One participant was also aware that there are few examples of manly men publicly acknowledging their depression and/or seeking help:

When you have an outspoken voice on the TV saying, 'I suffer from depression' it makes it that much easier for women to come forward and say, 'Yeah, I also suffer from it' but you don't see, like, Arnold Schwarzenegger coming up saying, 'Yeah, I do suffer from depression', right? You don't see that and you never will. (37 years, BDI 39)

A strong expectation expressed was that that men should be able to deal with their problems and that the reluctance to seek help was grounded in a fear of being judged. So, while depression was a point of departure from masculine ideals, avoiding help-seeking minimised any additional potential stigma:

I just felt, 'Oh no, I'm a man and I can just deal with it and it's not going to bother me', and definitely, definitely, definitely I have problems just kind of asking for help, like I just don't want to bring anything up. Not only the fact that I feel like I shouldn't have to; I also feel scared they're going to judge me and stuff like that. (26 years, BDI 42)

The men framed depression as difficult to interpret and act on, in contrast with physical problems that have tangible symptoms. For example, a 24-year-old man pointed out, 'I can know exactly what is the temperature of my body, but when I'm depressed, I don't know if I'm in a very critical situation'. Accordingly, softer solutions that demanded self-disclosure and introspection were easily dismissed. Talk therapy was particularly suspect for a self-reliant man because talking was viewed as something anyone could do:

For me, I still don't know if a therapist could help you medically, like, if you talk. But as compared to other things like a cold or something, you have some physical cure for it. So this thing is not really convincing for me, like, I wasn't really comfortable going to a

therapist. Because I felt, like, if talking can help me then I can help myself. (24 years, BDI 7)

The men whose talk aligned with this discursive frame openly or subtly ridiculed other men who sought help, demonstrating the power of this perspective. Some men valorised self-reliance by casting aspersions on the entire mental healthcare system, suggesting that there may be ulterior motives for the development of depression-related services:

I don't need to go to a doctor. I don't need to like have someone see me and monitor me and watch me but we've created a whole industry for just depression, it's a huge industry. (43 years, BDI 14)

The men who invoked the self-reliance discourse reproduced closely the dominant discourse on men's help-seeking, assuring us that they rarely went to the doctor. To seek help from a physician was constructed as a sign of weakness.

Treatment-seeking as responsible, independent action

The discourse of treatment-seeking as responsible, independent action was also strongly aligned with hegemonic masculine identities, but in an action-oriented way. The men revised the dominant discourse of help-seeking by choosing terms like doing and taking and deciding in relation to their own help-seeking, as opposed to receptive terms like being in therapy or receiving help. This discursive frame was suggested in the narrative of a 40-year-old man who described staying in bed all day because of his depressive symptoms but after prompts from his girlfriend to see a doctor acknowledged that his passivity was counter-productive and perhaps counter to hegemonic ideals:

I mean it's fairly new to me to think in terms of, 'Oh, I'm depressed or I have depression' ... and I had a really hard time with it actually kind of wrapping my head around, 'You know what, it's okay' and you know, 'Let's at least try this', it had not been a way of maybe dealing with something that I've been dealing with the wrong way. (40 years, BDI 17)

This man's initial resistance to help-seeking did not transform into a position of surrendering; instead, he positioned help-seeking as a way of actively dealing with his depressive symptoms.

This discursive frame references masculine ideals in which the necessity of opposing help-seeking is assumed but which acknowledges a time and place for rational and responsible approaches to help-seeking. For example, a 38-year-old man who had been married for 16 years described the pathway that eventually led him to seek help:

You know, if you're sick of being miserable and don't know why you want to be miserable ... [you] tried not being miserable but [are] still being miserable, then it's time for you to seek help. (38 years, BDI 16)

This man, a father with two children, described his decision to accept medication from a doctor as the responsible thing to do; saying, 'You know what, you have to *do* something'. Seeking professional help and taking treatment for his depression were integrated with his masculine identity and active fathering role.

The men described independently taking action or accepting help amid an emphasis that exhausting one's inner resources was the necessary first step before turning to professional

help. Only after a man had fully wrestled with depression on his own could he turn to others for help. This frame maps onto the dominant discourse of help-seeking that requires a threshold of pain or suffering be met, and it elaborates the terms from the perspective of hegemonic masculine ideals. For example, the idea of investigating or making an appointment to examine management options, meet potential caregivers or ask questions was not described. A 34-year-old man who had been diagnosed with depression and who had discontinued taking medication insisted that he had never had a problem asking for help. For this man the appropriate circumstances to ask for help were, 'if I ever hit that point' of suicide. A 42-year-old married man with three children advised men to:

... do a lot of reading, hours and hours and hours, absorb everything that you can and then you'll probably come to the realisation, self-diagnose yourself, and then are willing to get treatment, reach out for treatment. (42 years, BDI 39)

His advice emphasised solitary, autonomous instructions for how to 'self-diagnose', as though this approach made help-seeking more credible, a masculine artefact of effective problem-solving.

This discursive frame also positioned problem-solving therapies in a more positive light. Therapies that fixed the problem (such as a chemical imbalance) or provided an active role for the man were favoured. A 28-year-old man described how he found cognitive-behavioural therapy (CBT) helpful for managing and preventing the onset of his depression-induced symptoms. He stressed the action component of help-seeking stating, 'I recommend those things [CBT] and then like, *doing* what they teach you. Like, actually *doing* it' (BDI 7). Perhaps because CBT provides clients with specific tools to change reactive and negative thinking styles, it was perceived by some men to be more aligned with masculine ideals around self-management. In contrast, therapeutic approaches that emphasised empathic listening or psychodynamic insight were considered suspect.

Guarded vulnerability

Guarded vulnerability is a paradoxical frame that emerged as men talked about how they were not coping well with their depression, while at the same time recognising their masculine ideals were threatened by revealing this vulnerability. The perception of vulnerability the men attached to asking for help had to be allayed to protect the masculine self. The men suggested they guarded their vulnerability by cautiously seeking assistance, limiting disclosure of their depression and minimising the severity of the depression experience or the magnitude of need.

A 30-year-old man diagnosed with depression framed his bipolar disorder as manageable because he exhibited restraint by not indulging in spending sprees during the manic phase:

The first time I was in there racing thoughts again, mania. Depression never lands me in there [hospital], kind of, like panic disorder didn't, it's just when my thoughts become so abstract that I can't think, like. I've never had anything, no delusions of grandeur, but I've talked a lot about bipolar. I never think, like, 'Oh my God, I'm God' or all these things, go out and spend all my money ... I've never, never had big problems with hallucinations or anything like that but it's always been losing grasp of being able to formulate a sentence. (30 years, BDI 30)

By comparing himself with men who experienced more severe symptoms, such as hallucinations, this man protects his masculine identity and any loss of self-esteem in being given a psychiatric classification.

The men underscored their reluctance to admit the defeat of their personal resources to address depression, resisting the subject position as patient, a characteristically 'feminine' position. In many cases, the experience of vulnerability was not related to the actual symptoms of depression (for example, sadness, anger and despair) so much as this experience of adopting the patient role and submitting to an interaction with a health professional, a threat that needed to be managed. A 40-year-old nurse formally diagnosed with depression described how, even though he worked in the healthcare system, he felt vulnerable consulting a new general practitioner (GP) and asking for help again:

I know I have all this education but it still was hard to bring it up and recently I even had a new doctor or I have a new GP and it was still that 'Okay, I'm going to have to tell a guy about this and share my feelings and explain why I've had' ... so I did have a bit more to actually say to him about it, you know, but it was a matter of going on the pills again discussing that with him. (40 years, BDI 20)

Similarly, a 24-year-old man self-identified as depressed explained that it was easy to ask his family for help, 'if I was with my family I was comfortable to tell them "OK, please help me";' and only when really ill could he go to a doctor for help. In requesting help from a family member instead of a professional, the men not only maintained confidentiality in relation to their illness, they avoided brushing up against institutional structures in which power relations enacted by class, education and ethnic differences became evident. Many men voiced the idea that disclosure of depression to a friend or spouse put them in a less vulnerable position than disclosure to a professional. A 46-year-old man compared the intimacy of help received from a circle of friends versus professional help:

For those who are fairly comfortable with being gay, even then [they] may opt to do the informal therapy, you know, talking to friends and what not. Which of course is helpful ... to have a network of friends that you can express your emotions and feelings about things to. That is very good. But there are times when, yeah, you need professional help. I think there is something with male culture, maybe it is brain chemistry. The male just doesn't want to express weakness. (46 years, BDI 7)

This passage reproduces the discourse that men must demonstrate an appropriate threshold of discomfort before seeking help, paired with the gendered assumption that asking for professional help makes men too vulnerable, too weak. A 26-year-old man who suffered with long-term depression also invoked this discourse by emphasising how he struggled alone for as long as possible, feeling overwhelmed and vulnerable, before going to the doctor:

I admitted it to myself for the months leading up to it. I hadn't been able to do very much with my school work, I was feeling overwhelmed, I was near the end of the history honors programme at university, very strenuous, lots and lots of reading and knew pretty well what was going on. I, you know, I knew that the diagnostic test for this (my parents both had depression) I need to do something about it, 'Can you help me?' and he went through his check list, his BDI, wrote me a prescription and that was it. (26 years, BDI 29)

In this passage, the man defends his need (familial history) to ask for professional help, but is further disappointed with the outcome of a prescription. The ending to the man's story, 'that was it', warns the listener of the danger a man puts himself in by requesting help from a doctor – he may be left with little more than a piece of paper in hand. The message embedded

in the discourse cautions that a man must keep up his guard when subjecting himself to medical encounters.

Paradoxically, the discourse of guarded vulnerability was also drawn upon to justify the decision to not seek professional assistance. In this instance, the discourse was taken up as a persuasive device to convince the listener that therapy was too threatening for a man, leaving him unprotected and 'scared' of professional authority. A 26-year-old man, formally diagnosed by a psychiatrist and GP, explained why receiving professional help was untenable:

R: Why have you refused counselling?

P: I'm scared.

R: Of what?

P: What I might say, what I'll do.

R: Do you think it would differ from what you're telling me today?

P: Yeah, I'd have to deal with it, 'coz when I walk out of this room I won't have to deal with it. I'd be able to go back to my life the way it was. If I go to counselling I'd have to go through all the steps. I'm scared of that, I'm scared of being straight ... I'm scared of knowing what's really my problem, why I smoke weed every day. I'm scared of who I really am. (26 years, BDI 24)

The discourse of guarded vulnerability is reminiscent of what Robertson (2007) identified as 'should care, don't care' in men's strategic acknowledgement of moral responsibility for self-health mediated by the hegemonic masculinity that ignores self-care. It is also a more nuanced and detailed framing of the discourse that manly men don't seek help.

Desperation

The discourse of desperation suggests that there is no choice but to seek help. The need for help is urgent and the alternative to help-seeking is dire and includes acute suffering, family dissolution or even death. The language that participants chose and the circumstances they described in locating their desperation reproduced, as well as resisted, the dominant discourse about men's depression-related help-seeking. For example, a 37-year-old lawyer recounted the circumstances leading to a fork in the road whereby his help-seeking emerged from a do or die situation:

I remember driving down a hill on 140th or 144th [street] coming back from the court and taking my foot off the brake and thinking, 'If I just didn't touch the brake I could just lose control, it would look like an accident, it would all be over', and that's when I thought ... 'I've got to do something about this, I've got to go to the hospital', so instead of turning right to go to work I turned left and went to the hospital and I checked myself in and I was there two weeks. (37 years, BDI 19)

Men's desperation help-seeking is positioned as a rational but time-sensitive choice, taken up in an emergency when they can no longer manage without professional help. The participants' desperate actions trumped and muted any notions of weakness and failed masculinities associated with depression and formal help-seeking. Instead, suspense and drama saturated men's narratives and this frame privileged actions that offered the possibility of recovery or preserving masculine ideals typically lost in being perceived as a depressed man.

The participants' desperation was revealed in the need for immediate, acute and specialised care rather than routine or appointment-based general services. For example, a 26-year-old

man (BDI 24) said, 'I can't remember who I phoned but I think it was maybe 911'; a 44-year-old man (BDI 22) 'curled up in a ball and called 911 and said "I need to talk to someone"; while a 43-year-old man (BDI 14) beckoned his girlfriend to 'call the police' amid his increasing pain and dysfunction. The urgent need for help that led most participants to emergency services might reasonably be claimed as an artefact of participants' reticence to engage professional health care. Indeed, the depression and help-seeking practices of many participants leading up to these crises aligned with the dominant discourse about how men should (and should not) manage their health and illness, signalling they had reached an appropriate stage of suffering to justify professional services. Within this context, the uptake of emergency care did not transgress their masculine ideals. A 26-year-old man explained:

I drove myself to the hospital and I was trying to kick in the hospital doors and trying to get in and then I walked right into the back and they put me in the suicide room. (BDI 42)

A less dramatic but nonetheless an urgent need for help was detailed by a 44-year-old participant:

I thought I was going nuts ... Something was happening and I drove to where his [doctor's] office was, I had no appointment, didn't have the forethought for an appointment because of what I was suffering. Arrived to be told that there wasn't any available but she [receptionist] could probably squeeze me in at the end of the day. I said 'Okay' and I sat down and she thought that was very strange but she didn't say anything. Then I either read every single word in a magazine or I just simply flipped through it. At the end of the day I was talking to the doctor: he let me talk for maybe almost 10 minutes, I don't know what the hell I was saying, and he says, 'You're having anxiety attacks'. (44 years, BDI 22)

In this scenario the participant finds solace in the diagnosis because it validates his self-surveillance, triage and help-seeking actions. Legitimated also is his foresight to act, conviction to wait and diligence in having the illness named and the problem addressed.

Emergency help-seeking was framed as a way to problem-solve a crisis and was compared to other life-threatening events:

You know, when you stop breathing and you have a breathing tube in your chest and you're in a coma for a week because you've overdosed to kill yourself then the second you open your eyes they say, 'Okay, we're letting you go'. Now, like, there's a problem, a big problem. That happened to me a couple of times. (37 years, BDI 39)

The participant stated that in what followed emergency rooms had 'revolving doors' whereby desperation-induced self-harm was regularly treated. He later acknowledged and shared the responsibility for this situation, and in doing so likened himself to an impulsive child:

The only time I've gotten help is when it's been at the very end of, you know, almost childish behaviour, right, like trying to end my life and it's almost like a tantrum, a bit, you know. Did I look for help other than that? I don't know that I did. (37 years, BDI 39)

What is evident here is the man's inability to communicate what he is feeling and the provider's incapability to accurately account for, and therefore treat, the root cause of an episodic but potentially lethal behaviour. This conundrum reflects commentaries and

empirical evidence connecting and contrasting men's behaviour and healthcare services with the overall poor health outcomes of men. It also demonstrates a degree of questioning of the dominant discourse that restricts men's help-seeking to conditions of extreme need.

This frame gave the participants a way to distance themselves from depression by suggesting they were seeking help for desperation rather than for depression. Desperation discourses could emerge from a multitude of circumstances that were not always exclusively linked to depression. For example, a 27-year-old man with the highest BDI score in the sample explained, 'My girlfriend and I, our relationship was incredibly devastating at the time, the result of that was my eating disorder'. He connected a dysfunctional relationship with an emergent reactive disorder implying a malignant mind-body connection. Yet, this participant positioned his help-seeking in relation to his suicidal ideation rather than his ongoing depression or eating disorder:

I was, like, 'I don't need help with an eating disorder, I need help because my girlfriend doesn't want me any more and I can't take it and I'm going to kill myself if I don't get help'. (27 years, BDI 48)

The power of this discourse is that the complexity of the desperation and crisis may camouflage the chronic underlying health issue, disguising the real purpose of seeking help.

Genuine connection

The discourse of genuine connection reflects men's willingness to talk openly and at length about their depression with healthcare providers with whom they have established a mutual understanding. In contrast to the dominant construction of masculinity – which emphasises competitiveness, self-reliance and the lack of emotional expression – the discourse of genuine connection highlights an alternative masculine ideal. It also constructs an alternative to the dominant discourse of men's help-seeking. A central feature of genuine connection is a stated desire to be understood as a person and have one's illness validated within this context before embarking on a treatment regime. Having their healthcare practitioner genuinely understand them as a person, the complexity of their lives and their depression – being 'known' – were recurring features of this discourse:

Um, it feels like they [doctors] don't really want to know anything like that, they try to diagnose you, whatever your situation, give you medication or work or do; whatever they have to, but it's, like, business, business, there's no personal level there. My doctor there ... he was a European guy that really just didn't want to know anything about you or about your family life or anything like that. But the doctor I got after him; he was always asking questions, you know, like 'How are the kids?' and, you know, he'd even remember. I'd say 'Oh my youngest boy got an academic award and he's in Europe and I got all excited for him and stuff' and then he would say, the next time (it would be three months later) and he'd say, 'Hey, oh how did your son like it in Europe?' I'd be, like, 'Hey', you know, like 'Yeah'. (44 years, BDI 27)

In this frame the traditional masculine, scientific model of being fixed with medication (a business approach) paled amid the emergence of more traditional feminine features, such as being understood and listened to in the context of a trusting, personal relationship. Similarly, a 40-year-old man spoke of his positive rapport with a GP, and therefore his willingness to relinquish some control:

I preferred my doctor's approach and, I mean, we talked about it a little bit and he said 'This is what I'd like to prescribe' and I said, 'Well, I'll give it a try'. (40 years, BDI 17)

Another key feature of this discourse is an articulated desire just to have someone listen. Some men linked the discourse of genuine connection to their relief of being given a diagnosis of depression as an affirmation of their help-seeking behaviour:

They might step back (from suicide) if you can get it off your chest ... I feel that's the best thing and then get medical treatment, because it is a disease, it's brain chemistry, it's not you, it's just the way you are, it's nothing to be embarrassed about. (42 years, BDI 39)

An aspect of the genuine connection discourse articulated how the men did not want to take a subordinate, deferential position as a patient. Rather, men talked of a desire for a collaborative partnership with their healthcare provider in which they felt connected, understood, listened to and validated. Again, many men spoke of their dissatisfaction with being offered medication when they had not been fully understood or listened to:

I went and saw the doctor and he gave me some Prozac and I didn't feel ... he just said, 'Oh', and he started talking about me getting out of school and all this stuff and I really didn't think he understood exactly what I was trying to get through to him at all. (26 years, BDI 42)

In describing his desire to work collaboratively with a caregiver, a 43-year-old man used an analogy of how nurses would treat an abscess. In being treated for depression, he did not want to be taken care of in the same childlike way but instead wanted expert and effective advice:

I guess because I came from the downtown eastside and I've seen like compassionate nurses, street nurses and compassionate, like, I've walked down there and had like abscesses and, you know, a street nurse, street buses ... like the mobile triage thingies would, like, call you in and, like, lance your abscess care, take care of you, and that's a bit like, almost like, me taking care of, like, a child. I wouldn't want that but I think that I have not met the doctor yet who has, who has said 'Okay, I see, here: this is what you need'. (43 years, BDI 14)

Men relied on the discourse of genuine connection to construct themselves as active, empowered participants in their relationships with healthcare providers. Paradoxically, an active, trusting relationship with a healthcare provider disrupted the dominant discourse of men's help-seeking but can be interpreted as an attempt to preserve traditional masculine ideals.

Discussion

These findings build on the work of other researchers who have described men's experiences with depression, masculine ideals and help-seeking, and further identify how help-seeking is informed by broader discourses related to masculinity and men's desires to make appropriate use of the healthcare system. Our findings confirm and extend Galasiński's (2008) conclusion that gender ideology influences the lived expression of depression and help-seeking in men. In

our study the gendered construction of help-seeking discourses took the form of five discursive frames: manly self-reliance, treatment-seeking as responsible independent action, guarded vulnerability, desperation and genuine connection. We must point out that because we interviewed men only in this study, we cannot state to what extent women experiencing depression might reference these discursive frames. Nonetheless, our findings clearly supported the macro-linkages between discourses of men's help-seeking for depression and discourses of masculinity. Although most of the men in our study reproduced the social discourses that restrain men from seeking professional help, in actuality, many of these men did seek out services for their depression.

It is persuasive to view discourses that construct men's lack of help-seeking in a negative light. Yet research has demonstrated that it is, in part, the ability to reframe problems that is extremely helpful in managing depression (Kelly *et al.* 2008). We need to consider public health interventions that may assist in shifting discourses that prevent men from seeking help when it is required and that also reinforce the positive ways in which men are caring for themselves. The men's descriptions of help-seeking were polarised between voices expressing a need for help and voices resisting help. There was a noticeable absence of a discourse position that offered a coherent approach to selecting a suitable healthcare provider and receiving satisfactory care. Due to these polarized discourses it is no wonder that the men we interviewed had little sense of how to have preliminary discussions with their care providers when their symptoms were in an early stage.

Earlier accounts of men's help-seeking positioned alignment to masculine ideals as either allowing or not allowing their uptake of professional healthcare services (Brownhill *et al.* 2005, Emslie *et al.* 2007, Noone and Stephens 2008, O'Brien *et al.* 2005); however, our findings reveal how challenges around reconciling masculinities with seeking professional medical help and accessing mental healthcare services are complicated by depression. The discourse of desperation is interesting in light of research that has conceptualised suffering and the response to illness to consist of a moral stance reflecting an individual's identity; for men a self that revolves around the need for autonomy and control (Charmaz 1999). Charmaz constructed a hierarchy of moral status regarding suffering, based on patient narratives and assigned to the medical emergency the highest status and the least blame. We agree that the men in our study who used the emergency room were adopting a moral perspective that also protected their masculine self. This may explain, at least in part, the predominance of men being seen in emergency rooms or with acute, severe exacerbations of depression. A more sophisticated analysis of men's emergency room usage (a place where men present more often than women) might better distil what circumstances (and their relationship to masculinities) lead men to engage (rather than not engage) with professional medical services.

The discourse of genuine connection represents an alternative to hegemonic masculinity around help-seeking, and perhaps reveals a shift towards the emergence of more integrated masculine approaches to health. The men who took up the discourse of genuine connection were able to forgo traditional views of what it means to be a man and describe their need for a caring relationship. The desire to be heard, accepted and supported that these men described may be viewed as similar to a minority of men's voices reported by Emslie *et al.* (2006). Interestingly, being merely prescribed medications was constructed as an affront to this connection. Readers may argue that men and women would both expect more than a quick fix; however, from a social constructionist perspective we contend that medical interactions are gendered and medical institutions have positioned the practice of seeking help as a feminised activity (Courtenay 2000). Patients receive different kinds of care depending on their gender and women are known to engage in more detailed discussions with

their physician regarding therapeutic interventions than men (Bertakis and Azari 2007). The presence of the discourse of genuine connection reminds us of the complexity of gender, and illustrates the capacity for masculinity to be enacted in ways that are richer than the one-dimensional constructions that privilege and therefore reify traditional voices of autonomy and stoicism.

The men's participation in this study underscores their high degree of interest in, and willingness to be reflective about, their depression. This reflection on help-seeking has been noted by other researchers (for example, Smith *et al.* 2008) and suggests that men are willing to be active agents in their own care. Similarly, Gough (2006) has cautioned against shaping health services to accommodate hegemonic masculinity because this approach implies that masculinity is part of an intractable and stable identity rather than viewing masculinity as flexible, changeable and varying across different groups of men.

Further, given that some men in this study were experiencing minimal depression (as indicated by their low BDI scores), future work in masculinities and help-seeking would be well served by acknowledging additional sites of help for depression (such as web resources, spouses and partners and peers) rather than positing professional healthcare services and the medical consult as the best or only legitimate place to account for men's help-seeking. Our findings have implications that point to the limits of locating help-seeking exclusively in professional medical services. For example, men's decisions and the pathways leading towards as well as away from professional services are influenced by dynamic interplays between structure and agency that engage, refute and reformulate masculine discourses. Health service providers and policymakers need to take men's orientation to help-seeking into account as they attempt to engage men with the health system. In the context of the findings of this study, this requires that health service providers and key decision-makers reflect critically on the ways in which they have positioned men and their respective health practices. We cannot assume that our current health services meet the needs of men with depression.

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